Ohana Behavioral Health
Hope And Healing

22605 SE 56th Street Suite 150,
Issaquah, WA 98029
p: (425) 686-9509 f: (425) 686-7260
office@ohanabehavioralhealth.com
www.ohanabehavioralhealth.com

NEW CLIENT INFORMATION

Child's Name:_____Today's Date: _____

Child's Age:_____Date of Birth (DOB):_____Legal Gender: _____

Gender Identity:_____Pronouns:_____Sexual Orientation:_____

Grade in school:_____School:_____

Parent's Name: _____

Parent's Name: _____

Parents are (choose one)___Married ___Separated ___Divorced ___Widowed___Living Together If separated or divorced, how old was the client when the separation occurred? _

The client is living with: _____ Both Parents _____ One Parent (please specify):_____

_____ Other (please specify):_____

Who has primary custody?_____Is there a parenting plan? ____Yes _____NO

Please describe the current visitation schedule (if any) and type of communication with the child's other parent(s):_____

_____

Who, and by what method, is best for making contact regarding the client?

_____

_____

Please list the client's siblings (including adopted and/or step siblings):

Name	**Biological, Adopted, or Step**	**Current Age**	**Gender**
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

Contact Information

Parent Name: _____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____May we leave a message? ___YES ___NO

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Cell Phone:_____ May we leave a message? ☐ YES ☐ NO

Work Phone:_____ May we leave a message? ☐ YES ☐ NO

Email:_____ May we email you? ☐ YES ☐ NO

Email is used primarily for billing purposes but can sometimes be used for scheduling. All invoice/statements will be sent electronically unless otherwise discussed.

Does parent live with the client? ☐ YES ☐ NO

Parent Name: _____

Address:_____ City:_____ State: _____ Zip: _____

Home Phone:_____ May we leave a message? ☐ YES ☐ NO

Cell Phone:_____ May we leave a message? ☐ YES ☐ NO

Work Phone:_____ May we leave a message? ☐ YES ☐ NO

Email: _____ May we email you? ☐ YES ☐ NO

Email is used primarily for billing purposes but can sometimes be used for scheduling. All invoice/statements will be sent electronically unless otherwise discussed.

Does parent live with the client? ☐ YES ☐ NO

If other caregivers, please list below:

Caregiver's Name: _____

Address:_____ City:_____ State:_____ Zip: _____

Home Phone:_____ May we leave a message? ☐ YES ☐ NO

Cell Phone:_____ May we leave a message? ☐ YES ☐ NO

Work Phone:_____ May we leave a message? ☐ YES ☐ NO

Email:_____ May we email you? ☐ YES ☐ NO

Email is used primarily for billing purposes but can sometimes be used for scheduling. All invoice/statements will be sent electronically unless otherwise discussed.

Does caregiver live with the client? ☐ YES ☐ NO

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HEALTH CARE INFORMATION

Primary care physician:_____Phone number: _____

Is there a history of exposure to drugs and/or alcohol __YES ___NO

Is there a history of abuse?___YES ___NO

Rate the client's physical health: ___Excellent ___Good ___Average

Currently taking medications?___YES ___ NO If yes, please specify: _____

Current or previous mental health disorder diagnosis?___YES ___ NO If yes, please specify:

_____

Please answer the following questions:

What brings the client to counseling? (e.g., main challenges/difficulties/stressors)

_____
_____
_____

Any previous Therapy/ Counseling Yes No If yes, describe where, when, how long, and what for?

_____
_____
_____

What do you hope to get out of counseling?

_____
_____
_____

Give 3 adjectives to describe the client:

_____

Is there any other information we should know?

_____
_____
_____

How did you hear about us? Relative Friend School Doctor/clinic Internet Other _____

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FINANCIAL RESPONSIBILITY INFORMATION

Name of Patient:_____DOB Patient____/_____/_____ Gender: _____

Address:_____City_____State_____Zip code _____

Home Phone:_____Mobile Phone: _____

****Email**:_____

Primary Insurance Information:

Subscriber Name:_____Subscriber Date of Birth:____/___/___Gender:___

Full Address:_____City_____State_____Zip code _____

Home Phone:_____Cell:_____Email:_____

Client Relationship to Subscriber: _____

Name of Insurance Company: _____

Subscriber's ID#_____Group # _____

Co-pay amount:_____Customer Service Phone # _____

Secondary Insurance Information:

Subscriber Name:_____Subscriber Date of Birth:____/___/___Gender:___

Full Address:_____City_____State_____Zip code _____

Home Phone:_____Cell:_____Email:_____

Client Relationship to Subscriber: _____

Name of Insurance Company: _____

Subscriber's ID#_____Group # _____

Co-pay amount:_____Customer Service Phone # _____

Financially Responsible Party Signature X_____

Date: _____

Fees for Clinicians (and Professional Associates) at Ohana Behavioral Health apply as follows: Initial session (1 hr) is billed at $250; Subsequent sessions (50 mins) are billed at $200 (PA $100) for individuals and $225 (PA $125) for families. Standard fees apply for 3rd party reports at $200 per ½ hour. The rate for cash paying clients for Clinicians is $160 per session. Longer sessions may occasionally be called for with fees prorated accordingly.

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Payment is due the same day of service and may be paid by check, cash, or card. **Cancellation Policy:** If you are unable to keep an appointment, please let us know at least 48 hours in advance of your appointment. Otherwise, there will be $100 late cancellation/ no-show fee. **Managed Care**: Payments made in part of in full by a managed care organization (MCO) require compliance to the regulations of your plan. As your policy is a contract between you and your carrier, it is your responsibility to check with your insurance provider to confirm terms and limitations of coverage. **If your insurance fails to pay, for whatever reason, you are responsible for the full-billed amount.**

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
	(scoring totals)						

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:
PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

PSC-17 Scoring

The PSC-17 can help primary care providers assess the likelihood of finding any mental health disorder in their patient. The brief and easy to score PSC-17 has fairly good mental health screening characteristics, even when compared with much longer instruments like the CBCL (Child Behavior Checklist by T. Achenbach).

A 2007 study in primary care offices compared use of the PSC-17 to simultaneous use of the CBCL in 269 children aged 8-15, showing reasonably good performance of its three subscales compared to similar subscales on the CBCL. The gold standard here was a K-SADS diagnosis, which is a standardized psychiatric interview diagnosis. These comparison statistics are summarized below, with positive and negative predictive values shown based on different presumed prevalence (5 or 15%) of the disorders. Providers should notice that despite its good performance relative to longer such measures, it is not a foolproof diagnostic aide. For instance the sensitivity for this scale only ranges from 31% to 73% depending on the disorder in this study:

K-SADS	Screen	Sensitiv-ity	Specific-ity	PPV 5%	PPV 15%	NPV 5%	NPV 15%
ADHD	PSC-17 Attention	0.58	0.91	0.25	0.53	0.98	0.92
	CBCL Attention	0.68	0.90	0.26	0.55	0.98	0.94
Anxiety	PSC-17 Internalizing	0.52	0.74	0.10	0.26	0.97	0.90
	CBCL Internalizing	0.42	0.88	0.13	0.38	0.97	0.90
Depression	PSC-17 Internalizing	0.73	0.74	0.13	0.33	0.98	0.94
	CBCL Internalizing	0.58	0.87	0.19	0.44	0.98	0.92
Externalizing	PSC-17 Externalizing	0.62	0.89	0.23	0.50	0.98	0.93
	CBCL Externalizing	0.46	0.95	0.33	0.62	0.97	0.91
Any Diagnosis	PSC-17 Total	0.42	0.86	0.14	0.35	0.97	0.89
	CBCL Total	0.31	0.96	0.29	0.58	0.96	0.89

W Gardner, A Lucas, DJ Kolko, JV Campo “Comparison of the PSC-17 and Alternative Mental Health Screens in an At-Risk Primary Care Sample” JAACAP 46:5, May 2007, 611-618

PSC-17 Internalizing score positive if ≥ 5
PSC-17 Externalizing score positive if ≥ 7
PSC-17 Attention score positive if ≥7
PSC-17 Total score positive if ≥15

“Attention” diagnoses can include: ADHD, ADD
“Internalizing” diagnoses can include: Any anxiety or mood disorder
“Externalizing” diagnoses can include: Conduct disorder, Oppositional Defiant Disorder, adjustment disorder with disturbed conduct or mixed disturbed mood and conduct