Patient Name: ______________________

Clinic Number: ______________________

GUNDERSEN
HEALTH SYSTEM®

DEPARTMENT OF BEHAVIORAL HEALTH CONSENT FOR TREATMENT

I voluntarily consent to treatment through Gundersen Behavioral Health.

I have received and had explained to me:

- Description of Services
- My Rights and Responsibilities
- The Grievance Procedure
- The Cost of Services
- Emergency Procedures

I understand that Gundersen Behavioral Health uses a multi-disciplinary care team that includes psychiatrists, psychologists, and other mental health and substance abuse care providers.

We are committed to protecting your health information. We create a record of the care and services you receive in our department. In accordance with the 2014 Mental Health Care Coordination Bill, we may disclose your health and/or mental health information to providers who are involved in taking care of you at our facility. Two exceptions are: 1) reporting either suspected or actual child abuse to the appropriate authorities as required by law, or 2) when not disclosing information would pose a clear threat of physical harm to one's self or others.

I will participate in the development of my treatment plan and care. As part of my treatment plan development, I will discuss the benefits of treatment, time frame of treatment, modality of treatment, possible side effects or risks, alternative modes or services, and consequences of not receiving treatment. I understand that the signing of my treatment plan indicates my consent to treatment as described by the plan and my provider.

I understand that I will need to attend regularly scheduled appointments as defined by my treatment plan. Failure to do so may result in discharge from care. If you do not have an appointment with your therapist or counselor in six months, that could be considered reason for discharge. If you do not have an appointment with your Psychiatry Prescriber in 12 months, that could be considered reason for discharge.

I understand that I can withdraw my consent for treatment at any time in writing. By signing below, this consent will remain in effect for 15 months from the date of my (patient/parent/legal guardian) signature.

______________________________ ______________

Patient Signature (required if 12 or over) Date

______________________________ ______________

Parent/Legal Guardian
(If patient is unable to sign or is under age of 18, please complete.) Date

______________________________ ______________

Staff Member Date

______________________________ ______________

Care Provider Date

Check if Applicable:

☐ **I understand that my provider is not currently licensed in the State of Wisconsin and is practicing under the supervision of another licensed provider according to any/all applicable laws and professional standards.**

Patient Name:______________________________

Medical Record Number:____________________

Addressograph

GUNDERSEN
HEALTH SYSTEM®

La Crosse, WI 54601

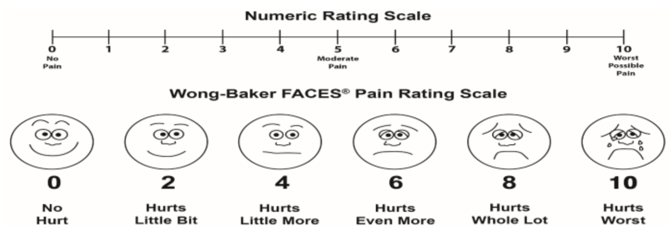
BEHAVIORAL HEALTH CHILD INTAKE SCREENING FORM

1. Who referred you to our clinic? ______________________________
2. What school do you attend? ______________________________
   What grade are you in? ______________________________
3. Do you wish others to be involved in your care? If so, please give name(s) and relationship to you.
   ____
   ____
4. Please list family members/others that will be involved in your care: ______________________________
   ____
5. Please describe the reason you are seeking services: ______________________________
   ____
   ____
6. Please list any prior mental health treatment: ______________________________
   ____
   ____

Please check any of the following that apply to you (or your child):

- ☐ Family problems
- ☐ Problems with friends
- ☐ School attendance problems
- ☐ Learning problems
- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Behavior Problems
- ☐ Thoughts of hurting yourself or others
- ☐ Past suicide attempt(s)
- ☐ Problems controlling anger
- ☐ Problems with appetite
- ☐ Weight Loss or Gain
- ☐ Changes in eating habits
- ☐ Growth or development problems
- ☐ Sexual Abuse
- ☐ Legal Issues
- ☐ Thoughts of Suicide
- ☐ Feelings of hopelessness
- ☐ Problems with irritability
- ☐ Problems with falling or staying asleep

Physical pain: ☐ Yes ☐ No If yes, please rate:



Medical History:

Primary Care Physician: ______________________________

Current Medications: ______________________________

____

Are you currently using tobacco? ☐ Yes ☐ No If yes, do you desire help with quitting? ☐ Yes ☐ No

Patient Signature: ______________________________ Date: __________

Parent/Guardian Signature: ______________________________ Date: __________

Provider Signature: ______________________________ Date: __________

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Name: ___________________________ Date: ___________________________

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, check √ the box that corresponds to the response that seems to describe you *for the last 3 months*.

	0 **Not True or Hardly Ever True**	**1** **Somewhat True or Sometimes True**	**2** **Very True or Often True**	
1. When I feel frightened, it is hard to breathe.				**PA/SO**
2. I get headaches when I am at school.				**SCH**
3. I don't like to be with people I don't know well.				**SOC**
4. I get scared if I sleep away from home.				**SEP**
5. I worry about other people liking me.				**GA**
6. When I get frightened, I feel like passing out.				**PA/SO**
7. I am nervous.				**GA**
8. I follow my mother or father wherever they go.				**SEP**
9. People tell me that I look nervous.				**PA/SO**
10. I feel nervous with people I don't know well.				**SOC**
11. I get stomachaches at school.				**SCH**
12. When I get frightened, I feel like I am going crazy.				**PA/SO**
13. I worry about sleeping alone.				**SEP**
14. I worry about being as good as other kids.				**GA**
15. When I get frightened, I feel like things are not real.				**PA/SO**
16. I have nightmares about something bad happening to my parents.				**SEP**
17. I worry about going to school.				**SCH**
18. When I get frightened, my heart beats fast.				**PA/SO**
19. I get shaky.				**PA/SO**
20. I have nightmares about something bad happening to me.				**SEP**

Screen for Child Anxiety Related Disorders (SCARED)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.				GA
22. When I get frightened, I sweat a lot.				PA/SO
23. I am a worrier.				GA
24. I get really frightened for no reason at all.				PA/SO
25. I am afraid to be alone in the house.				SEP
26. It is hard for me to talk with people I don't know well.				SOC
27. When I get frightened, I feel like I am choking.				PA/SO
28. People tell me that I worry too much.				GA
29. I don't like to be away from my family.				SEP
30. I am afraid of having anxiety (or panic) attacks.				PA/SO
31. I worry that something bad might happen to my parents.				SEP
32. I feel shy with people I don't know well.				SOC
33. I worry about what is going to happen in the future.				GA
34. When I get frightened, I feel like throwing up.				PA/SO
35. I worry about how well I do things.				GA
36. I am scared to go to school.				SCH
37. I worry about things that have already happened.				GA
38. When I get frightened, I feel dizzy.				PA/SO
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).				SOC
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.				SOC
41. I am shy.				SOC

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. Journal of the American Academy of Child and Adolescent Psychiatry, 38(10), 1230–6.

The SCARED is available at no cost at www.pediatricbipolar.pitt.edu under resources/instruments.

January 19, 2018

Screen for Child Anxiety Related Disorders (SCARED) CHILD Version

TO BE COMPLETED BY CLINICIAN

Name: ________________________________ Date: ________________________________

SCORING:

A total score of ≥ **25 may** indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL=**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 **may** indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PA/SO =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 **may** indicate **Generalized Anxiety Disorder**. **GA=**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 **may** indicate **Separation Anxiety Disorder**. **SEP=**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 **may** indicate **Social Phobic Disorder**. **SOC =**

A score of **3** for items 2, 11, 17, 36 **may** indicate **Significant School Avoidance Symptoms**. **SCH=**

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D.,
Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. Journal of the American Academy of Child and Adolescent Psychiatry, 38(10), 1230–6.

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January 19, 2018

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is a 20-item self-report depression inventory with possible scores ranging from 0 to 60. Each response to an item is scored as follows:

0 = "Not At All"

1 = "A Little"

2 = "Some"

3 = "A Lot"

However, items 4, 8, 12, and 16 are phrased positively, and thus are scored in the opposite order:

3 = "Not At All"

2 = "A Little"

1 = "Some"

0 = "A Lot"

Higher CES-DC scores indicate increasing levels of depression. Weissman et al. (1980), the developers of the CES-DC, have used the cutoff score of 15 as being suggestive of depressive symptoms in children and adolescents. That is, scores over 15 can be indicative of significant levels of depressive symptoms.

Remember that screening for depression can be complex and is only an initial step. Further evaluation is required for children and adolescents identified through a screening process. Further evaluation is also warranted for children or adolescents who exhibit depressive symptoms but who do not screen positive.

See also

Tool for Families: Symptoms of Depression in Adolescents, p. 126.

Tool for Families: Common Signs of Depression in Children and Adolescents, p. 147.

REFERENCES

Weissman MM, Orvaschel H, Padian N. 1980. Children's symptom and social functioning self-report scales: Comparison of mothers' and children's reports. *Journal of Nervous Mental Disorders* 168(12):736–740.

Faulstich ME, Carey MP, Ruggiero L, et al. 1986. Assessment of depression in childhood and adolescence: An evaluation of the Center for Epidemiological Studies Depression Scale for Children (CES-DC). *American Journal of Psychiatry* 143(8):1024–1027.

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number ____________________

Score ____________________

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	_____	_____	_____	_____
2. I did not feel like eating, I wasn't very hungry.	_____	_____	_____	_____
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	_____	_____	_____	_____
4. I felt like I was just as good as other kids.	_____	_____	_____	_____
5. I felt like I couldn't pay attention to what I was doing.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	_____	_____	_____	_____
7. I felt like I was too tired to do things.	_____	_____	_____	_____
8. I felt like something good was going to happen.	_____	_____	_____	_____
9. I felt like things I did before didn't work out right.	_____	_____	_____	_____
10. I felt scared.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	_____	_____	_____	_____
12. I was happy.	_____	_____	_____	_____
13. I was more quiet than usual.	_____	_____	_____	_____
14. I felt lonely, like I didn't have any friends.	_____	_____	_____	_____
15. I felt like kids I know were not friendly or that they didn't want to be with me.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	_____	_____	_____	_____
17. I felt like crying.	_____	_____	_____	_____
18. I felt sad.	_____	_____	_____	_____
19. I felt people didn't like me.	_____	_____	_____	_____
20. It was hard to get started doing things.	_____	_____	_____	_____

Gundersen Health System Trauma Informed Care

Name: **Date:**

About Your Child

Being a parent is not easy. We want to help families have a safe environment for their children. We are asking parents these questions which are about situations that affect many families. If you have a concern, we'll try to help in order to decrease the likelihood of long term health effects as your child grows up. To improve our healthcare of your child, this information will be shared with your child's primary care physician and become part of the medical record. We encourage you to ask any additional questions you may have.

Please check *yes* or *no* to the following questions. If you are distressed by answering these questions, please let us know. We are here to help.

Since your child was born, have you worried that:

1. A parent or other adult in the household swore at your child, insulted them, put them down, or acted in a way that made your child afraid they might be physically hurt?
   NO___ YES ___
2. A parent or other adult in the household pushed, grabbed, slapped, or threw something at your child or ever hit your child so hard that there were marks or injuries?
   NO ___ YES ___
3. An adult or person at least 5 years older than your child ever touched your child sexually or tried to make your child touch their body sexually?
   NO ___ YES ___
4. Your child has felt that no one in the family loved them or thought they were special or caregivers have not been able to be a source of strength, support or protection for your child?
   NO ___ YES ___
5. Your child didn't have enough to eat, has not had anyone take them to the doctor or a parent or caregiver were too drunk or high to take care of your child?
   NO ___ YES __
6. Biological parent was ever lost to your child through divorce, abandonment, or other reason?
   NO ___ YES___
7. Your child saw parents or other adults in the home push, grab, slap, or throw things or hit with a fist, or hit with something hard, or threaten each other with a gun or a knife?
   NO ___ YES ___
8. Your child has lived with someone who was a problem drinker or alcoholic, or who used street drugs?
   NO___ YES ___
9. A household member was depressed or mentally ill, or attempted suicide?
   NO___ YES___
10. A household member went to prison?
    NO___ YES ___

***Note:** There are, of course, many other types of childhood trauma – watching a sibling being abused, losing a caregiver, being bullied, homeless, surviving and recovering from a severe accident, etc. If your child experienced other types of toxic stress over months or years, then those would likely increase their risk of health consequences.

Please note other stressful experiences for your child here:

Office Use Only – Number of questions answered **YES** ________

Instructions for scoring

- The ACE score is calculated by adding up the total of **YES** responses

How to interpret

- An ACE score of 0 suggests there are no reported childhood events which link to poor health outcomes in adulthood
- An ACE score of 1, 2, or 3 suggests that stressful events in childhood may be a factor in poor health outcomes in adulthood. As the score increases, there is a cumulative higher risk of poor health outcomes.
- An ACE score of 4 or more is correlated with significantly poorer long term health outcomes

What to say

- For long term health and well-being, it is important to keep significantly stressful experiences to a minimum, particularly during the childhood years, but also in adulthood for family and community health

References-

Felitti, V.J., Nordenberg, D. et.al (1998) The relationship of adult health status to childhood abuse and houseold dysfunction. American Journal of Preventive Medicine, 14, 245-258

Felitti, V. J ., Anda, R.F. The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behavior: implications for Healthcare. In R. Lanius, E. Vermetten and C. Pain (ed.) The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic, Cambridge University Press, 2010.

O'Connor, C., Finkbiner, C., & Watson, L. (2012) Adverse Childhood Experiences in WI: Findings from the 2010 Behavioral Risk Factor Survey. Madison, WI: WI Children's Trust Fund and Child Abuse Prevention Fund of Children's Hospital & Health System.