

**ACKNOWLEDGEMENT OF RECEIPT OF THE  
NOTICE OF PRIVACY PRACTICES  
OF  
Plaza Family Care**

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_ of  
Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone \_\_\_\_\_  
No: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby acknowledge that I have received from Plaza Family Care a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how Plaza Family Care may use and/or disclose my personal health information both with and without my authorization. I further understand that I may contact the Privacy Officer if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of Plaza Family Care.

\_\_\_\_\_  
Signature of Patient or Patient's  
Representative

Date

# HIPAA NOTICE OF PRIVACY PRACTICES

Plaza Family Care, PC  
657 Willow Grove Street  
West Wing – Suite 401  
Hackettstown, NJ 07840  
908.850.7800

## **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

### **1. Uses and Disclosures of Protected Health Information**

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health Issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect: Food & Drug Administration requirements: Legal Proceedings, Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.**

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### Your Rights

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to restrictions that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.** Upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. (908.850.7800)

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**FAMILY CARE, PC**

Children's Center • Adult Medical Center

**PEDIATRICS/INTERNAL MEDICINE**

West Wing Medical Plaza • (Behind HRMC)

657 Willow Grove Street - Suite 401

Hackettstown, NJ 07840

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245 Main Street

Suite 300/302

Williamson Building

Chester, NJ 07930

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**908.850.7800**

## FINANCIAL POLICY

*We are committed to providing the best possible care to our patients and their families, and feel this goal is best achieved if everyone is aware of our office policies. Your clear understanding of our financial policy is important to our professional relationship.*

*We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. Full payment is expected at the time of service. This especially includes applicable deductible and co-payments for participating insurance companies. Plaza Family Care, PC., accepts cash, personal checks, Visa, Master Card and American Express. You will be given an itemized statement every time you or your child is seen in the office.*

*The benefit packages provided by insurance companies vary from employer to employer. Medical insurance is a contract between you, your employer and your insurance company. Not all services are a covered benefit in all contracts. You need to learn the benefits in your policy (including vaccine and well-child coverage) and follow the rules of the policy (such as authorization for specialty care, procedures, lab tests and emergency room use). We will bill the insurance companies we participate with, but if we are not paid in a timely fashion, you will be expected to pay the bill in full. Except as provided by such contract or by State law, we will hold you responsible for all charges. Any services rendered to you or your children that are not a covered benefit according to your insurance will be billed to you.*

*If you are experiencing financial difficulty, please let us know. In no case will a patient present to our office, with an urgent problem, be turned away because of financial problems.*

*If you need assistance or have any questions, our billing staff can be reached at (908) 850-7800 between the hours of 8:30 a.m. and 4:30 p.m. Monday through Friday.*

*Every minor child, under age 18, seen in our offices for medical services must be accompanied by a parent or legal guardian, or by an adult who has obtained written consent for treatment from the parent or legal guardian. An exception is an adolescent presenting for confidential services, which we are permitted by State law to provide without notifying the parent.*

*The accompanying parent or other adult is responsible for full payment at the time of service and must have the proper insurance card. In the case (such as divorce), where the custodial parent is not the insurance holder, we will bill the covering insurance company or non-custodial parent. If there should be a dispute about the financial responsibility, we will then hold the accompanying adult responsible for payment. It will then be up to him/her to seek repayment from the other parent. We find it very difficult to look after your child's medical care when we are placed in the middle of a marital dispute.*

*If your insurance plan requires us to complete a referral in order for you or your child to see a specialist, or for procedures or lab tests, you must allow three (3) business days to complete the appropriate forms prior to obtaining services. Retroactive referrals cannot be processed and will not be honored. In general, we will not agree to a referral for a problem we have not been consulted with first.*

*Our referral department (908) 850-7800, can be of great assistance in answering your questions, but please do not ask them to violate insurance contracts or our office policies.*

*Broken appointments are a cost to us, to you, and to other patients who could have used the time set aside for your appointment. Please call us at least 24 hours in advance to make any scheduling changes you need. We reserve the right to charge a \$25.00 fee to your account if we find that you continue to miss appointments without advance notice. Excessive abuse may result in dismissal from the practice. There is a fixed \$125.00 fee for missed Neurodevelopmental appointments.*

*As stated above, all fees are due at the time of service. Any charges remaining unpaid sixty (60) days after the date of service are considered past due. In this case, we will make every effort to contact the person responsible for the delinquent balance, and arrange an equitable payment schedule. However, if no effort is made to pay the balance due, it may be sent to a collection agency. In this case the responsible person will be asked to seek medical care for themselves and their families elsewhere.*

- I have read and understand the Plaza Family Care, PC financial policy.*
- I agree to keep Plaza Family Care, PC accurately informed of my insurance status for either myself and/or family members and to assign benefits to Plaza Family Care, PC.*

\_\_\_\_\_  
Signature of Insured or Authorized Representative

Date: \_\_\_\_\_



Date \_\_\_\_\_

Child's Name \_\_\_\_\_

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

- |   |     |    |
|---|-----|----|
| 1. Does your child enjoy being swung, bounced on your knee, etc?  | Yes | No |
| 2. Does your child take an interest in other children?  | Yes | No |
| 3. Does your child like climbing on things, such as up stairs?  | Yes | No |
| 4. Does your child enjoy playing peek-a-boo/hide-and-seek?  | Yes | No |
| 5. Does your child ever pretend? (e.g., talk on the phone or take care of dolls or pretend other things?)                 | Yes | No |
| 6. Does your child ever use his/her index finger to point, to ask for something?  | Yes | No |
| 7. Does your child ever use his/her index finger to point to indicate an interest in something?                           | Yes | No |
| 8. Can your child play properly with small toys (e.g., cars or bricks) without just mouthing, fiddling, or dropping them? | Yes | No |
| 9. Does your child ever bring objects over to you (parent) to show you something?   | Yes | No |
| 10. Does your child look you in the eye for more than a second or two?  | Yes | No |
| 11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)   | Yes | No |
| 12. Does your child smile in response to your face or your smile?   | Yes | No |
| 13. Does your child imitate you? (e.g., you make a face, will your child imitate it?)                                     | Yes | No |
| 14. Does your child respond to his/her name when you call?  | Yes | No |
| 15. If you point at a toy across the room, does your child look at it?  | Yes | No |
| 16. Does your child walk?   | Yes | No |
| 17. Does your child look at things you are looking at?  | Yes | No |
| 18. Does your child make unusual finger movements near his/her face?  | Yes | No |
| 19. Does your child try to attract your attention to his/her own activity?  | Yes | No |
| 20. Have you ever wondered if your child is deaf?   | Yes | No |
| 21. Does your child understand what people say?   | Yes | No |
| 22. Does your child sometimes stare at nothing or wander with no purpose?   | Yes | No |
| 23. Does your child look at your face to check your reaction when faced with something unfamiliar?                        | Yes | No |

HEALTHY KIDS PROGRAM  
**Medical/Family History Questionnaire**

Practice Name: \_\_\_\_\_ Date of Entry: \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
 \_\_\_\_\_ Emergency No.: \_\_\_\_\_  
 Source of Information: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Mother's Pregnancy/Child's Birth History: (under 2 years old)**

Illnesses during pregnancy? No Yes  
 Any medications during pregnancy? No Yes  
 Alcohol/Drug Abuse? No Yes  
 Problems at birth? No Yes  
 Describe: \_\_\_\_\_  
 Type of delivery? Vaginal C-section  
 Birth Weight \_\_\_\_\_ Discharge Weight \_\_\_\_\_  
 Did baby receive Hepatitis B vaccine? No Yes  
 Date of Hepatitis B immunization: \_\_\_\_\_  
 Name of Hospital: \_\_\_\_\_  
 Was first PKU done? No Yes

**Patient's Health History: Has your child every had...**

Measles/Mumps/Chicken Pox? No Yes  
 Frequent ear infections? No Yes  
 Vision/Hearing Problems? No Yes  
 Skin Problems? No Yes  
 Asthma/Allergies? No Yes  
 TB/Lung disease/Croup? No Yes  
 Seizures/Epilepsy? No Yes  
 High Blood Pressure? No Yes  
 Heart Defects/Disease? No Yes  
 Liver disease/Hepatitis? No Yes  
 Diabetes? No Yes  
 Kidney Disease/Bladder Infections? No Yes  
 Handicaps/Disabilities? No Yes  
 Bleeding Disorders/Hemophilia? No Yes  
 Sexually Transmitted Diseases? No Yes  
 Emotional Problems/Suicide Attempts? No Yes  
 Hospitalizations/Surgeries? No Yes  
 Physical/Emotional Abuse/Broken bones? No Yes  
 Immunizations Up-to-date? No Yes

**Psycho-Social History:**

How many living in the household? \_\_\_\_\_  
 Who cares for child? \_\_\_\_\_  
 Are parents working? \_\_\_\_ Yes \_\_\_\_ No  
 Name of School? \_\_\_\_\_  
 Grade: \_\_\_\_\_  
 Behavior problems? \_\_\_\_\_

**Family History:** Has anyone in the family (parents, grand-  
 parents, aunts/uncles, sisters/brothers, cousins, etc.) had the following:

	No	Yes	Who
TB/Lung Disease?	_____	_____	_____
HIV/AIDS?	_____	_____	_____
Suicide Attempts?	_____	_____	_____
Heart Disease?	_____	_____	_____
High Blood Pressure?	_____	_____	_____
High Cholesterol?	_____	_____	_____
Blood Disorders?	_____	_____	_____
Diabetes?	_____	_____	_____
Seizures?	_____	_____	_____
Allergies/Asthma?	_____	_____	_____
Mental Illness?	_____	_____	_____
Mental Retardation?	_____	_____	_____
Cancer?	_____	_____	_____
Birth Defects?	_____	_____	_____
Hearing/Speech Problems?	_____	_____	_____
Kidney Disease?	_____	_____	_____
Alcohol/Drug Abuse?	_____	_____	_____
Stroke?	_____	_____	_____
Hepatitis/Liver Disease?	_____	_____	_____
Thyroid Disease?	_____	_____	_____
Learning Problems?	_____	_____	_____
Attention Deficit Disorder?	_____	_____	_____
Family Violence?	_____	_____	_____

**Adolescent History: (interview separately)**

Age at first period \_\_\_\_\_ LMP \_\_\_\_\_  
 Sexually Active? No Yes # of partners? \_\_\_\_\_  
 Sex of partners? M/F  
 Any fears of partner/other violence? No Yes  
 Smoker? No Yes Alcohol Use? No Yes  
 Drug Use? No Yes Working? No Yes  
 Do you think about hurting yourself? No Yes  
 Access to gun/weapon? No Yes

Provider: \_\_\_\_\_  
 Date: \_\_\_\_\_

Comments: \_\_\_\_\_

Updates: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Heart Disease/Cholesterol Risk Assessment:**

(2 years through 20 years)

1. Is there a family history of parents/grandparents under the age 55 years with heart attack/surgery stroke, high blood pressure, high cholesterol, sudden death, or diabetes?
2. Is there personal history of:  
Smoking?  
  
Lack of physical activity?  
  
High blood pressure?  
  
High cholesterol?  
  
Obesity/overweight?

**STD/HIV Risk Assessment:**

(11 through 20 years)

1. Have you had a blood transfusion or are you currently diagnosed with Hemophilia?
2. Have you ever been sexually molested or physically attacked?
3. Have you ever been diagnosed with any sexually transmitted diseases (gonorrhea, syphilis, venereal warts, chlamydia, herpes)?
4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?
5. If sexually active, have you had unprotected sex, with opposite/same sex (circle appropriate response)?
6. If sexually active, have you had more than one sex partner?
7. Any body tattoos or piercing of ears, navel, etc., including any performed by friends?

**Tuberculosis Risk Assessment:**

(Initial visit and yearly thereafter)

1. Was your child born in, or lived more than a year in a country other than the U.S?  
Where? \_\_\_\_\_ Year? \_\_\_\_\_
2. Has your child been exposed to anyone with either active tuberculosis or a history of tuberculosis disease?
3. Is your child currently living in a household with anyone who is HIV positive?
4. Is your child part of a migrant worker family?

**Lead Risk Assessment:**

(6 months to 6 years)

1. Does your child currently live, or has he/she ever lived in a house or apartment built before 1960 (includes day care center, preschool home, home of babysitter or relative)?
2. Is anyone in the home being treated or followed for lead poisoning?
3. Are there any current renovations or peeling paint in a home that your child regularly visits?
4. Is there any family member who is currently working in an occupations or hobby where lead exposure could occur? (auto mechanic, ceramics, commercial painter, etc.)

**NEURODEVELOPMENTAL CLINIC**  
**PLEASE PLACE A CHECK MARK TO THE LEFT OF ANY**  
**QUESTION 1-62 WHICH YOU WOULD ANSWER "YES"**

1. Was this child more active in utero than his/her siblings?
2. Did you smoke or drink during pregnancy?
3. Was the child's birth weight low?
4. Was he/she colicky?
5. Was he/she a tense or easily agitated baby/toddler?
6. Was/is he/she a "climber"?
7. Is he/she accident prone? Have there been serious injuries?
8. Have there been any serious illnesses or accidents?
9. Did, or does he/she have sleep problems?
10. Is your child a very restless sleeper?
11. Does your child have trouble getting up in the morning?
12. Does your child have frequent nightmares?
13. Was your child hard to toilet train, or does he/she have persistent bed wetting?
14. Does your child have problems getting ready for school?
15. Does he/she have problems with changes in schedules?
16. Did/does your child have problems with changes in his/her environment?  
Do things always need to be the same?
17. Is your child overactive, always in motion?
18. Can your child sit through a meal?
19. Does your child have an extreme, "sweet tooth," or sugar craving?
20. Can he/she sit quietly and watch TV?
21. Is he/she hard to contain on car trips?
22. Does he/she make strange or involuntary noises?
23. Is he/she, "twitchy," does he/she make sudden movement?
24. Does your child have learning problems?
25. Are there people in your families with ADHD or learning problems?
26. Did your child have problems in pre-school?
27. Does your child have gross or fine motor skill problems?
28. Is your child's handwriting legible, (if old enough to write)?
29. Is your child preoccupied with computer or video games?
30. Is your child witty, funny, the class clown?
31. Does your child have unusual or overwhelming fears?
32. Is your child often moody?
33. Do your child's moods change very quickly?

34. Does your child like to play with Legos, video games, puzzles?
35. Does your child seem inattentive or distractible at home?
36. Does your child seem inattentive or distractible at school?
37. Does your child procrastinate or have trouble planning projects?
38. Does he/she do better 1:1 than in a group?
39. Is his/her performance inconsistent?
40. Does he/she lose personal items, forget assignments?
41. Does your child have a, "one track mind?"
42. Can your child handle more than one thing at a time?
43. Does your child interrupt, make rude/inappropriate comments?
44. Is your child a, "daredevil"?
45. Does your child play with matches or fire?
46. Does he/she have trouble controlling anger?
47. Is he/she often controlling, bossy, trying to be in charge?
48. Does he/she have trouble making or keeping friends?
49. Does he/she seem immature compared to others his/her age?
50. Does your child often say that no one likes him/her or that he/she is "dumb?"
51. Is your child often disobedient, argumentative, oppositional?
52. Does he/she often lie or steal?
53. Does he/she have problems following rules?
54. Does he/she have problems sharing?
55. Has your child begun to withdraw from friends, family, normal activities?
56. Does your child lack energy, always seem tired?
57. Has your child's behavior changed recently?
58. Is this child more, "high maintenance," than sibs or relatives?
59. Does your child have problems with authority or authority figures?
60. Has your child ever threatened or tried to harm him/herself?
61. Is your child more comfortable with adults, or younger or older children than with his/her classmates?
62. Do your child's problems limit him/her in school and at home?
63. Do both parents think there is a problem?

When do you think your child's problems began?

What do you think is wrong with our child? Do you have a diagnosis?

What have you tried so far?

# Healthy Kids

## MENTAL HEALTH WELLNESS QUESTIONNAIRE

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Managed Care Organization: \_\_\_\_\_ Child's Medicaid #: \_\_\_\_\_

Ages 0 - 2

*Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.*

Does your child have trouble following your movement around the room with his eyes? .....  Yes  No

Does your child rarely laugh or smile? .....  Yes  No

Does your child not want to play with family members or other children? .....  Yes  No

Does your child have trouble paying attention? .....  Yes  No

Does your child seem nervous or afraid? .....  Yes  No

Does your child seem late learning to talk? .....  Yes  No

Does your child have trouble sleeping? .....  Yes  No

During pregnancy did the mother use:

Alcohol .....  Yes  No

Drugs .....  Yes  No

Tobacco .....  Yes  No

*(Continued on back)*

# Healthy Kids

Is there a history of injuries, accidents? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there any history of maltreatment or abuse? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there a recent stress on the family or child such as :

- Birth of a child .....  Yes  No
- Moving .....  Yes  No
- Divorce or separation .....  Yes  No
- Death of a close relative .....  Yes  No
- Fired or laid off .....  Yes  No
- Legal problems .....  Yes  No
- Others (Please specify): \_\_\_\_\_  Yes  No

Do you have other parenting concerns? .....  Yes  No  
Please specify: \_\_\_\_\_

**Provider:** Give details of all Positive findings.

\_\_\_\_\_  
Provider's Signature  
Provider's Phone: (\_\_\_\_) / \_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Date

***THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS***

Child Receiving Referral: \_\_\_\_\_  
Child's Address: \_\_\_\_\_  
Child's Phone: \_\_\_\_\_  
Referred to: \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

# Healthy Kids

## MENTAL HEALTH WELLNESS QUESTIONNAIRE

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Managed Care Organization: \_\_\_\_\_ Child's Medicaid #: \_\_\_\_\_

**Ages 3 - 5**

**Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.**

Does your child often wet or soil his pants? .....  Yes  No

Does your child have problems at day care or school? .....  Yes  No

Do you have any concerns about your child:

Daydreaming .....  Yes  No

Paying attention .....  Yes  No

Sitting still .....  Yes  No

Does your child :

Refuse to obey .....  Yes  No

Refuse to play with others .....  Yes  No

Does your child get tired easily? .....  Yes  No

Does your child often seem:

Sad .....  Yes  No

Angry .....  Yes  No

Nervous or afraid .....  Yes  No

Cranky .....  Yes  No

Not interested .....  Yes  No

Does your child have trouble sleeping? .....  Yes  No

Does your child have problems with eating? .....  Yes  No

Is your child often mean to animals or smaller children? .....  Yes  No

*(Continued on back)*

# Healthy Kids

Is there a history of injuries, accidents? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there any history of maltreatment or abuse? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there a recent stress on the family or child such as :

- Birth of a child .....  Yes  No
- Moving .....  Yes  No
- Divorce or separation .....  Yes  No
- Death of a close relative .....  Yes  No
- Fired or laid off .....  Yes  No
- Legal problems .....  Yes  No
- Others (Please specify): \_\_\_\_\_  Yes  No

Do you have other parenting concerns? .....  Yes  No  
Please specify: \_\_\_\_\_

**Provider:** Give details of all Positive findings.

\_\_\_\_\_  
Provider's Signature  
Provider's Phone: (\_\_\_\_) / \_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Date

***THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS***

Child Receiving Referral: \_\_\_\_\_  
Child's Address: \_\_\_\_\_  
Child's Phone: \_\_\_\_\_  
Referred to: \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

# Healthy Kids

## MENTAL HEALTH WELLNESS QUESTIONNAIRE

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Managed Care Organization: \_\_\_\_\_ Child's Medicaid #: \_\_\_\_\_

Ages 6 - 9

*Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.*

Does your child often seem:

- Distrustful of others .....  Yes  No  
Have trouble paying attention .....  Yes  No  
Blame others .....  Yes  No

Do you have concerns about your child's:

- Eating .....  Yes  No  
Sleep .....  Yes  No  
Weight .....  Yes  No

Does your child often complain of "not feeling well"? .....  Yes  No

Does your child have problems getting along with:

- Parent(s) .....  Yes  No  
Other family members.....  Yes  No  
Friends .....  Yes  No  
School mates .....  Yes  No

Does your child have problems at school with:

- Behavior .....  Yes  No  
Grades .....  Yes  No  
Not wanting to go to school .....  Yes  No

Does your child often seem:

- Sad .....  Yes  No  
Angry .....  Yes  No  
Nervous or afraid .....  Yes  No  
Cranky .....  Yes  No  
Not interested .....  Yes  No

Does your child often:

- Destroy property .....  Yes  No  
Lie .....  Yes  No  
Steal .....  Yes  No  
Hurt animals or smaller children .....  Yes  No

*(Continued on back)*

# Healthy Kids

Is there a history of injuries, accidents? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there any history of maltreatment or abuse? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there a recent stress on the family or child such as :

- Birth of a child .....  Yes  No
- Moving .....  Yes  No
- Divorce or separation .....  Yes  No
- Death of a close relative .....  Yes  No
- Fired or laid off .....  Yes  No
- Legal problems .....  Yes  No
- Others (Please specify): \_\_\_\_\_  Yes  No

Do you have other parenting concerns? .....  Yes  No  
Please specify: \_\_\_\_\_

**Provider: Give details of all Positive findings.**

\_\_\_\_\_  
Provider's Signature  
Provider's Phone: (\_\_\_\_) / \_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Date

***THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS***

Child Receiving Referral: \_\_\_\_\_  
Child's Address: \_\_\_\_\_  
Child's Phone: \_\_\_\_\_  
Referred to: \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

# Healthy Kids

## MENTAL HEALTH WELLNESS QUESTIONNAIRE

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Managed Care Organization: \_\_\_\_\_ Child's Medicaid #: \_\_\_\_\_

**Ages 10 - 12**

*Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.*

- Does your child have trouble paying attention? .....  Yes  No
- Does your child often seem:
- Distrustful of others .....  Yes  No
  - To express strange thoughts .....  Yes  No
  - Blame others .....  Yes  No
- Does your child have problems at school with:
- Behavior .....  Yes  No
  - Grades .....  Yes  No
  - Skipping classes .....  Yes  No
- Do you have concerns about your child's:
- Eating .....  Yes  No
  - Sleep .....  Yes  No
  - Weight .....  Yes  No
- Does your child often complain of "not feeling well"? .....  Yes  No
- Does your child have trouble making or keeping friends? .....  Yes  No
- Does your child often seem:
- Sad .....  Yes  No
  - Angry .....  Yes  No
  - Nervous or afraid .....  Yes  No
- Does your child show any of these behavior:
- Destroy property .....  Yes  No
  - Set fire .....  Yes  No
  - Lie .....  Yes  No
  - Steal .....  Yes  No
  - Listen to music with violent message .....  Yes  No
  - Hurt animal or smaller children .....  Yes  No
  - Use alcohol .....  Yes  No
  - Use drugs .....  Yes  No
  - Smoke cigarettes .....  Yes  No
  - Sexually active .....  Yes  No

(Continued on back)

# Healthy Kids

Is there a history of injuries, accidents? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there any history of maltreatment or abuse? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there a recent stress on the family or child such as :

- Birth of a child .....  Yes  No
- Moving .....  Yes  No
- Divorce or separation .....  Yes  No
- Death of a close relative .....  Yes  No
- Fired or laid off .....  Yes  No
- Legal problems .....  Yes  No
- Others (Please specify): \_\_\_\_\_  Yes  No

Do you have other parenting concerns? .....  Yes  No  
Please specify: \_\_\_\_\_

**Provider:** Give details of all Positive findings.

\_\_\_\_\_  
Provider's Signature  
Provider's Phone: (\_\_\_\_) / \_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Date

<b><i>THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS</i></b>	
Child Receiving Referral:	_____
Child's Address:	_____
Child's Phone:	_____
Referred to:	_____
Reason for Referral:	_____
	_____

# Healthy Kids

## MENTAL HEALTH WELLNESS QUESTIONNAIRE

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Managed Care Organization: \_\_\_\_\_ Child's Medicaid #: \_\_\_\_\_

Ages 13 - 20

*Check all answers that may apply. This form may be filled out by the patient, parent/guardian or health care provider.*

- Do you have trouble paying attention? .....  Yes  No
- Do you often:
- Feel distrustful of others .....  Yes  No
  - Have strange thoughts .....  Yes  No
  - Hear voices .....  Yes  No
  - Have to do things the same way or keep repeating them .....  Yes  No
- Do you have problems at school with:
- Behavior .....  Yes  No
  - Grades .....  Yes  No
  - Skipping classes .....  Yes  No
- Do you worry about your:
- Eating .....  Yes  No
  - Sleep .....  Yes  No
  - Weight .....  Yes  No
- Do you have trouble making or keeping friends? .....  Yes  No
- Do you often feel:
- Sad .....  Yes  No
  - Angry .....  Yes  No
  - Nervous or afraid .....  Yes  No
- Have you thought about or done any of the following:
- Destroy property .....  Yes  No
  - Hurt animals .....  Yes  No
  - Set fire .....  Yes  No
  - Listen to music with violent message .....  Yes  No
  - Use alcohol .....  Yes  No
  - Use drugs .....  Yes  No
  - Smoke cigarettes .....  Yes  No
  - Sex without protection.....  Yes  No
  - Suicide attempt .....  Yes  No

(Continued on back)

# Healthy Kids

Is there a history of injuries, accidents? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there any history of maltreatment or abuse? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there a recent stress on the family or child such as :

- Birth of a child .....  Yes  No
- Moving .....  Yes  No
- Divorce or separation .....  Yes  No
- Death of a close relative .....  Yes  No
- Fired or laid off .....  Yes  No
- Legal problems .....  Yes  No
- Others (Please specify): \_\_\_\_\_  Yes  No

Do you have other parenting concerns? .....  Yes  No  
Please specify: \_\_\_\_\_

Provider: Give details of all Positive findings.

\_\_\_\_\_  
Provider's Signature  
Provider's Phone: (\_\_\_\_) / \_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Date

***THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS***

Child Receiving Referral: \_\_\_\_\_  
Child's Address: \_\_\_\_\_  
Child's Phone: \_\_\_\_\_  
Referred to: \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_