LifeSteps Lewisville I
Patient Registration Forms

Welcome to our facility! We would appreciate you taking a few minutes to complete this in its entirety.
If you need help or have any questions, please do not hesitate to contact one of our fine staff. Thank you!

CHILD INFORMATION				
Child's Name:		DOB:		Male Female
Address:			SSN:	
City:	ST:	Zip:	Has your child received therapy in the last year from the public school system?	❑ Yes ❑ No

PARENT INFORMATION				
Mother:			Home #:	
Address(if different from above):			Cell #:	
City:	ST:	ZIP	Work#:	
email:	Occupation:			Place of Employment:
Father:			Home #:	
Address(if different from above):			Cell #:	
City:	ST:	ZIP	Work#:	
Email:	Occupation:			Place of Employment:

EMERGENCY CONTACTS		
Contact Name	Telephone Number	Relationship
1.		
2.		

PHYSICIAN INFO			
Primary Care/Pediatrician:			
Address:			Work #:
City:	ST:	ZIP	Fax#:
Referring Physician (if different from above):			
Address:			Work #:
City:	ST:	ZIP	Fax#:

BILLING INFO				
Funding Source:	❑ Private Pay	❑ Medicaid	Medicaid #	Effective Date

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FAMILY COMPOSITION	*Please answer the following questions by checking the appropriate answer*				
1.	Does the child live with both parents?	Yes	No		
	If not, with whom does he/she live?				
2.	Any siblings?	Yes	No	Ages: ________________	

3.	Individuals living in home			Parents or siblings living outside home		
	Member	Relationship	Age	Member	Relationship	Age

4.	Was the child adopted?	Yes	No	If yes, at what age?		
5.	With whom does the child spend most of his/her time?			Mother	Father	Grandparents
				Daycare	Other	
6.	If school or day care, please provide the following:			Name of School:		
				Grade:	City:	

BACKGROUND	*Please answer the following questions by checking the appropriate answer*			
1.	What is your main concern/the reason you have brought your child in for this evaluation?			
2.	When was the problem first noticed and by whom?			
3.	Has there been an abrupt change since problem was first noticed?		Yes	No
4.	Is the child aware of the problem?		Yes	No
	If so, how does he/she feel about it?			
5.	Does your child receive special services?	❑ ECI	❑ Home Health	❑ Nursing
	Other:			
	For children 3 and under: Do you need information about ECI?		Yes	No
6.	Has your child received speech/physical/occupational therapy in the past?		Yes	No
	If yes, when and where?			
7.	Is your child currently being seen by any other specialist?		Yes	No
	If so, what kind?			
8.	Has your child received any diagnosis?		Yes	No

9.	Please describe your child:	Aggressive	Cooperative	Uncooperative	Happy
	Shy	Sociable	Attentive	Enjoys playing w/ others	Doesn't enjoy playing with others
	Other				
10.	Any behavioral issues?		❑ Yes ❑ No		
	If yes, please explain:				
11.	How does the child usually communicate wants and needs?		Gestures	Gesture/Vocalization	
	Gestures/Jargon	Gestures/True Words	Single Words	Phrases	Sentences
	Other:				
11.	What language(s) does your child speak primarily?	English	Spanish	Other	

PRENATAL & BIRTH HISTORY
Please answer the following questions by checking the appropriate answer

1.	Length of Pregnancy:		Birth Weight:		
2.	List medications that the mother took during the pregnancy, if any:				
3.	Type of Delivery:	Natural	Induced Labor	C-Section	Breech
		Forceps Used	Suction Used		
4.	Please list any complications during the pregnancy:				
5.	Did the child require NICU stay?		Yes	No	
	Why?				

DEVELOPMENTAL HISTORY
Please answer the following questions by checking the appropriate answer

1.	Please indicate if your child has difficulty with any of the following:			Writing	Grasping		
	Coloring	Running	Dressing	Walking	Activities requiring small muscles		
	Activities requiring large muscles	None					
2.	Please indicate if your child has any of the following feeding problems:			Chewing	Sucking	Spilling	
	Sensitive to certain textures	Swallowing	Cup Drinking	Drooling	Oral Sensitivity		
	Spilling food from spoon	None					
3.	Does your child fall or trip frequently (seems clumsy)?	Yes	No				
4.	At approximately what age did your child begin to do the following activities?	Rolling		Sitting			
	Crawling		Standing		Walking		
	Feed Self		Dress Self				
	Use Toilet		Combine Words		Use Single Words		
	Use Simple questions		Engage in Conversation				
5.	Please describe your child's response to sound:	Responds to all sounds	Responds to loud sounds only				
	Inconsistently responds sound	Other					

LIVING ENVIRONMENT
Please answer the following questions by checking the appropriate answer

1.	Type of dwelling:	House	Apartment	
	Other: ____			

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2.	Please indicate if your home has any of the following:		Stairs, no railing		Stairs, with railing	Ramps
	Uneven Terrain	Any Obstacles	Any other structured barriers: ______________________________			
3.	Please indicate if your child has any of the following:		Motorized Wheelchair		Manual Wheelchair	
	Cane	Walker	Crutches	Stander	Shower Chair	Glasses
	Hearing Aids					

FAMILY & PATIENT GOALS	***Please answer the following question***
1.	What are your goals for your child's therapy?

MEDICATIONS	***Please list the medications that your child is currently taking***
1.	

ALLERGIES	***Please list any types of allergies your child has, if known***
1.	

SOCIAL SERVICES			
1.	Are you able to pay the rent, buy food, pay electric bill and buy medications as needed?	Yes	No
2.	Do you have the resources you need to best provide for your child / family?	Yes	No
3.	Are you having stress, anxiety or depression related to your child's diagnosis or medical condition?	Yes	No
4.	Do you have family support to assist you with the needs of your child?	Yes	No
5.	Would you like to discuss anything with our Social Worker?	Yes	No

COUNSELING	***Please answer the following questions by checking the appropriate answer***				
1.	Has your child received counseling in the past?			❑ Yes	❑ No
	Psychological or neuropsychological testing?			❑ Yes	❑ No
	Medication for behavior problems?			❑ Yes	❑ No
	If yes, what agency or individual treated him/her?				
2.	Child is most often disciplined by whom?				
3.	Discipline **most** effective with the child				
	Least effective				
4.	Do parents agree on how to discipline?			❑ Yes	❑ No
5.	Has child ever been physically abused?			❑ Yes	❑ No
	Sexually abused?			❑ Yes	❑ No
	If yes, please explain?				
6.	Does your teen use:	Alcohol	Cigarettes	Drugs	
7.	Please indicate if any of the following issues which may be affecting your child:			Parental separation or divorce	
	Remarriage or new partner	Custody dispute	Family violence	Conflict between parents	
	Absence of parent	Financial stresses	Psychiatric illness	Recent or multiple moves	
	Health problems	Death in the family	Drug or alcohol abuse		

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SOCIAL DEVELOPMENT	*Please answer the following questions by checking the appropriate answer*				
1.	Does your child have problem relating with:	Children of own age	Brothers/Sisters	Parents	
		Teachers	Other adults		
2.	Does your child like to play with children:	Own age	Younger	Older	
3.	Does your child have:	Many friends	Few friends	No friends	
4.	Does your child have problems separating:	Mother	Father	Neither	
5.	Is your child a :	Leader	Follower	Loner	
6.	Has your child ever has problems involving the police or juvenile authorities?	Yes	No		
	If yes, please explain:				
7.	Child religion:	________________________________			
8.	Has your child ever repeated a grade?	Yes	No	If yes, grade?	
9.	How many schools has your child attended?				
10.	Is your child in Special Education/ARD meetings?	Yes	No	If yes, which service?	Resource
		Content mastery	Behavior Improvement	Life Skills	
		Alternative school	504		
11.	Is your child currently experiencing difficulty in school?	Yes	No		
	If yes, please explain:				

I certify that the above information is correct to the best of my knowledge. I will not hold my therapist/doctor/ nurse or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature:		Date:	
Reviewed By:		Date:	

I have reviewed the questions above and I (circle one) do or do not believe that I have any needs that would require Social Services at this time, and I do understand that LifeSteps offers this service if my situation changes.

Patient/Guardian Signature:_____________________________________ Date: ______________________

Reviewed By: _____________________________________ Date: ______________________

<u>For Children under 3 years of age</u>

I have been informed of ECI services and I am declining them for my child in lieu of service at this center of this time.

Patient/Guardian Signature: _____________________________________ Date: ______________________

Reviewed By: _____________________________________ Date: ______________________

LifeSteps Lewisville I
Notice of Privacy Practices

Record of Acknowledgement

Name of Patient: ____ Date: ____________________

We are committed to preserving the privacy and confidentiality of your health information whether created by us and/or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are also required by state and federal regulations to abide by the privacy practices described in the notice provided to you including any future revisions that we may make to the notice as necessary or as authorized by law.

Effective Date of This Privacy Notice

The effective date of this *Privacy Notice* is April 22, 2009

Changes or Revisions to our Privacy Notice

We reserve the right to change our facility's *Privacy Notice* at any time and to make revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise or change our *Privacy Notice,* we will post a copy of the new or revised notice in our lobby. You may obtain a copy of the new/revised *Privacy Notice* from our business office.

Privacy Notices, Information Restrictions, Record Amendment/Corrections, Disclosures of Information, Revoking an Authorization, Inspection and Copying of Records, Confidential Communications, Filing Complaints, Etc.

Should you have any comments, questions and/or complaints concerning our facility's privacy practices, please contact:

Chris Japak, Compliance Officer
401 N Valley Pkwy Suite 380
Lewisville, Texas 75067
Ph (972) 353-5437

You may also file complaints with:
U.S. Dept of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free (877) 696-6775

Acknowledgment

I certify that a copy of this facility's Privacy Notice was made available to me for review and ask questions to assist me in understanding my rights relating to the protection of my health information. I understand that a copy is available for me to take upon request. I am satisfied with the explanations provided to me. I am confident that the facility is committed to protecting my health information.

Date: ______________ Signature of Patient /Representative ______________________________

Printed Name of Patient/Representative ______________________________

Relationship to Patient if Representative ______________________________

A copy of this record must be provided to the person making the request and a copy must be filed in the clients' medical record

LifeSteps Lewisville I
Client Rights

POLICY: The Client has the right to be informed of his or her rights. The Facility will explain and comply with these rights for all Clients admitted to the Facility.

PROCEDURE:

A. The Client has the right to be informed of his or her rights. This Facility will protect and promote the exercise of these rights.
B. This Facility will provide the Client with a written notice of the Client's rights in advance of furnishing care to the Client or during the initial evaluation visit before the initiation of treatment.
C. The Facility will maintain documentation showing that the Facility has complied with the requirements pertaining to Client Rights.
D. The Client has the right to exercise his or her rights as a Client of this Facility.
E. The Client's family or guardian may exercise the Client's rights when the Client has been judged incompetent.
F. The Client has the right to have his or her property treated with respect.
G. The Client has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of this Facility and will not be subjected to discrimination or reprisal for doing so.
H. The Facility will investigate complaints made by a Client or the Client's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the Client's property by anyone furnishing services on behalf of the Facility, and the Facility will document both the existence of the complaint and the resolution of the complaint.
I. The Client has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.
J. The Client has the right to participate in the planning of their care.
K. The Client has the right to confidentiality of their clinical records maintained by the Facility.
L. The Facility will advise the Client of policies and procedures regarding disclosure of clinical records.
M. The Client has the right to be advised, before care is initiated, of the extent to which payment for the Facility services may be expected from Medicare/Medicaid or other source, and the extent to which payment may be required from the Client.
N. Before the care is initiated, the Facility must inform the Client, orally and in writing of:
    1. The extent to which payment may be expected from Medicare, Medicaid, or any other federally funded or aided program known to the Facility.
    2. The charges that the individual may have to pay.
O. The Client has the right to be advised orally and in writing of any changes pertaining to payment for services expected from Medicare/Medicaid or other sources, and the extent to which payment may be required from the Client when they occur. The Facility will advise the Client of these changes orally and in writing as soon as possible, but no later than 30 calendar days from the date the Facility becomes aware of a change.

Signed: Parent/Guardian/Responsible Party	Date

Signed: Facility Representative	Date

LifeSteps Lewisville
Medical Treatment Consent

As a parent or legal guardian I hereby indicate my wish to have my child be a participant in the rehabilitation program offered by Life Steps Lewisville I.

I understand Life Steps Lewisville I does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities. This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Regulations of the U.S. Department of Health and Human Services. For further information about this policy, contact:

Shanda Bickelhaupt at (972) 353-KIDS (5437)

In the event that the Doctor orders a Psychological Evaluation, Social Services Evaluation and/or treatment for your loved one, your signature on this document indicates permission from you to provide this evaluation and bill Medicare, Medicaid, or other insurance for it.

I understand that the purpose of this program is to enhance your child's recovery from an injury, or illness and or improve their daily living skills, personal safety and functional movements in the management of developmental conditions. I further understand that there exists the possibility that certain changes may occur during my treatment.

I have also been informed of the procedures and methods of treatment that will be administered to my child, and I fully understand what is required of me as a Client.

I verify that my child's participation is fully voluntary, no coercion of any sort has been used to obtain their participation, and you may withdraw them from treatment at any time.

I understand that the clinical director maintains an open-door policy and encourages parents to participate in treatment sessions.

Signed: Parent/Guardian/Responsible Party	Date

LifeSteps Lewisville I
Financial Responsibility Consent

I, ____________________________, as parent/guardian to _______________________ do accept financial responsibility for services accepted from LifeSteps Lewisville 1 for any or all Occupational, Physical, Speech Therapies, Professional Counseling, and/or Nutrition Counseling.

I understand that I am responsible for payment in exchange for any/all of these services. LifeSteps accepts Medicaid, Medicaid CHiPs, some private insurances, and private pay via Fee for Services.

I understand that managing my insurance coverage and processing is primarily my responsibility and that LifeSteps may not be and is not required to be contracted with all Medicaid and commercial insurances. It is my responsibility to know my coverage limitations for in and out of network and work with LifeSteps to ensure they have all the information they need to recover payments for their services that I accept.

As a Medicaid participant, I understand that LifeSteps will file directly with my insurance carrier for payment in return for services rendered. I understand that LifeSteps will not seek additional payment from me for services not covered by my Medicaid Insurance program i.e. Amerigroup, Aetna Medicaid, Cooks Medicaid and related CHiPs programs. I understand that under some Chips programs, a co-payment may be required at the time of service.

As a Commercial Insurance participant with secondary insurance coverage through Medicaid or another commercial insurance plan, I understand that LifeSteps will bill all available insurance sources to recover payment for services that I accept. This may require me to pay co-payments at the time of service.

As a Private Pay client of LifeSteps, I understand that the fee for service will be required at the time of service. LifeSteps accepts cash, check and credit card payments. The fee for service was agreed with me prior to my appointment. I understand that LifeSteps does not have a financial payment plan. If I default on required payments, LifeSteps has the right to cancel all services and discharge my child/dependant.

I understand that it is my responsibility to inform LifeSteps if my insurance coverage changes prior to the next scheduled visit.

I understand that there will be a $30.00 fee charged to me for returned/insufficient checks and that this fee and the next visit will be paid in cash.

Signed: Parent/Guardian/Responsible Financial Party	Date

LifeSteps Lewisville I
Grievance Policy

Policy: Life Steps Lewisville I has adopted an internal grievance procedure to provide for prompt and equitable resolution of grievances. The facility will initiate a complaint/grievance procedure to assure fair and consistent handling of employee, contractor, and client complaints. All complaints will be investigated by the facility within 10 business days of receipt of complaint, providing employee, contractor, and client with a clear and open channel for expressing complaints, based on a procedure that contains the right to appeal.

Procedure:

A. If an employee, contractor, or client feels they have been unlawfully discriminated against, sexually harassed, or had their personal rights violated, the complaint must be in writing and filed with the Administrator. If the complaint is against the administrator, then the complaint must be filed with another member of facility management or the Governing Body. The grievance must be filed within 14 days.

B. Grievances must be in writing and contain the following information: name and address of the person filing the grievance and a brief description of the events. The written grievance will be dated when received by the Administrator.

C. The Facility Administrator or designee will conduct an investigation of the grievance to determine its validity. The investigation will be thorough, allowing all interested or involved parties or their representatives an opportunity to submit evidence relevant to the grievance.

D. Sworn statements alleging unlawful discrimination will be investigated by facility management within three (3) working days. After investigating the matter, facility management shall take whatever corrective and/or preventative action is deemed appropriate under the circumstances. The action may include disciplinary action, up to and including immediate termination of the violator(s) of the policy.

E. An employee, contractor, or client who files a complaint of discrimination, sexual harassment, or violation of personal rights in good faith will not be retaliated against by an employee or contractor of the facility regardless of the outcome of the complaint. If the complaint is found to have been filed maliciously, however, disciplinary action may be taken against the employee or contractor filing the malicious complaint.

F. The Administrator or designee will issue a written decision determining the validity of the grievance no more than 30 days from the date the grievance was filed.

G. The Administrator shall maintain records related to grievances. The Administrator may assist persons in the preparation and filing of the grievance, assist in the investigation, and advise the Administrator or designee concerning the resolution.

H. The rights of a person to prompt and equitable resolution of the grievance shall not be impeded by the person's pursuit of other remedies such as filing a Section 504 Grievance with the Office for Civil Rights of the U.S. Department of Health and Human Services.

I. Determination made under these procedures shall be liberally constructed to protect the substantial rights of interested parties, to meet appropriate due process standards, and to assure the compliance of Life Steps Lewisville I with Section 504.

J. A copy of this policy will be reviewed and signed by all employees and clients and kept in their appropriate file.

K. A copy of this policy will be furnished up request to all contractors.

Signed: Parent/Guardian/Responsible Party	Date

LifeSteps and Family Therapy Services Contract

LifeSteps appreciates you and your child and we look forward to creating an experience that is safe, comfortable, fun and timely. We need your help. Please indicate your commitment to help us create a terrific experience every time you visit us:
(Please Initial)

_____ I agree to help keep the lobby clean and comfortable and safe for all kids by keeping all food in the designated snack area. I understand that this is important because some kids have food allergies or could choke if food is left on the ground.

_____ I understand that food can only be taken past the lobby under Therapist direction.

_____ I know that there are many clients that would like to receive services at LifeSteps and I will make every attempt to be at my scheduled appointments. If I cannot be there, I will call to reschedule my appointment as soon as possible in order to give LifeSteps the opportunity to call another child for that time.

______ I understand that if I have a pattern of not calling to cancel or missing days and times that LifeSteps will discuss alternative therapy times. If another appointment time cannot be agreed upon, my child's number of days/visits may be reduced or my child may be discharged. If the pattern persists, my child may be discharged.

______ Making sure my child gets the most out of their therapy is important to me and LifeSteps. I will make every effort to arrive at my appointments on-time so that my child can get started promptly and so other therapy sessions do not run late.

______ I understand that if my child's scheduled therapy session(s) will be less than 1 hour, I must stay in the clinic. **IF** my child's session is less than 1 hour and I must leave, I understand that I must provide an immediate contact number; leave items necessary for my child (i.e. diapers), and return promptly, 15 minutes before the therapy end time to meet with the therapists.

______ I know that I am responsible to provide basic needs for my child while at LifeSteps (i.e. diapers, bottles, snacks….)

______ LifeSteps provides several services for the benefit of my child and me, as a parent. In doing so, it is my responsibility to ensure my children who not attending therapy, are supervised while in the clinic. If I am receiving counseling or meeting privately with a therapist, I understand that it is my responsibility to ensure proper supervision for my children (i.e. through a family member or care giver). It is not LifeSteps staff's role to supervise my children.

_____ PT/OT sessions involve physical movement. In order for my child to get the most out of their therapy sessions, I will ensure they have tennis shoes and proper clothing for the session.

Signed: Parent/Guardian/Responsible Party	Date

Life Steps Lewisville I
Discharge Policy

POLICY: Clients will be discharged from services when services are no longer necessary or justifiable. Discharge can be initiated by the facility or the client/family.

PROCEDURE:

A. The professional team comprised of representatives from all disciplines will meet at client case review conference to review client's progress and to continue the process of discharge planning.

B. Each client's case will be handled individually with regard to discharge.

C. Prior to discharge, the professional team will discuss the client's continued needs and identify appropriate services and/or agencies for further referral. This information will be coordinated with the client/family if accessible and communicated to the referring physician.

D. The following is a list of potential reasons for discharge including but not limited to:

1. Upon achieving maximum rehab potential where all goals established at initial Plan of Care have been met.
2. The inability to make the necessary commitment to therapy as evidenced by:
   a. A drop in attendance to 50% in any 30-day period or
   b. Three un-notified absences, Consideration will be given for unavoidable circumstances.
   c. Hospitalization resulting in a newly diagnosed condition different from the original diagnosis received with the initial therapy order. If the new diagnosis warrants therapy services, a new physician's order will be obtained.
3. Admission to a home health or hospice agency.
4. Parent/guardian request to cease therapy.

E. A discharge summary will be documented. The summary will include:

1. The client's current physical status relative to goal achievement.
2. The client's prognosis along with considerations for future treatment if necessary.
3. Coordination with the referring physician for another level of care, if necessary.

F. A copy of the discharge summary will be forwarded to the referring physician.

G. As needed, the client will be provided with carry-over ideas for home and or school or work. Such ideas may include a written functional home exercise/maintenance program to prevent decline of functional mobility.

Client Name: ____ Date: ___________________

Client/Responsible Party

Signature: ____

LifeSteps
Therapy for Kids

Medication Record

Client Name: ____________________________ DOB:_________________

Date	Current Medications/ Medication Changes

REVIEW OF SYMPTOMS

CLIENT NAME: **DOB:**

Yes	No	**ADHD**	
		Impulsivity	
		Physical or verbal over activity	
		Inattention	
		Difficulty with organization	
		Distractibility	
Yes	**No**	**ODD**	
		Tantrums	
		Argumentative	
		Blames others	
		Challenges rules	
		Easily frustrated	
Yes	**No**	**MOOD**	
		Depressed, irritable or expansive	
		Social withdrawal or isolation	
		Wt., appetite, sleep, or energy changes	
		Motor retardation, acceleration, agitation	
		Psychic retardation, acceleration, agitation	
		Feeling worthless	
		Indecisiveness	
		Suicidal ideation, attempt or plan	
		Morbid preoccupation	
		Grandiosity	
		Hypersexuality	
		Homicidal ideation, attempt or plan	
Yes	**No**	**CONDUCT**	
		Verbal or Physical aggression	
		Destruction of property	
		Deceitfulness or theft	
		Violations of rules	
		Run away behavior or truancy	

LifeSteps Therapy for Kids

REVIEW OF SYMPTOMS

CLIENT NAME: **DOB:**

Yes	No	Item	Comments
		Fire Setting	
Yes	**No**	**MOTOR**	
		Tics	
		Stereotypies	
Yes	**No**	**ANXIETY**	
		Worries or fears	
		Nervous habits, obsessions compulsions	
		Separation, school refusal, avoidance	
		Somatization	
Yes	**No**	**PSYCHOSIS**	
		Hallucinations/ delusions	
		Bizarre behavior, beliefs or speech	
		Disorganized thoughts	
Yes	**No**	**PDD**	
		Impaired social interactions	
		Ritualistic, repetitive behaviors	
		Loss of skills	

Comments: ____

____

Are Immunizations Current: YES NO

Nutritional Needs/Medications: ______________________________

Medication Allergies: ______________________________

Other Allergies: ______________________________

Surgeries: ______________________________

Medical History: ______________________________

Completed by: ______________________________

LifeSteps Therapy for Kids

PSYCHOSOCIAL HISTORY

CLIENT NAME: **DOB:**

Evaluation of Problem: ____

____

____

Custody/Visitation Issues: ____

____

Activities/Hobbies: ____

____

Mother's Family of Origin: ____

____

____

Father's Family of Origin: ____

____

____

Other Significant Family Circumstances/Stressors: ______________________________________

____

____

____

Family Dynamics: ____

____

____

____

Barriers to Learning: ____

____

Additional Referrals ____

____

Completed by: ____

TREATMENT PLAN

CLIENT NAME: **DOB:**

PROBLEM LIST:

1. ____
2. ____
3. ____

DIAGNOSIS:

Axis I: ______________________ R/O ______________________

______________________ R/O ______________________

______________________ R/O ______________________

Axis II: ______________________ R/O ______________________

______________________ R/O ______________________

Axis III: ______________________ R/O ______________________

______________________ R/O ______________________

Axis IV: ____

Axis V: Current: _________ Highest in last 12 months: _________

DATE	PROBLEM#	SHORT TERM GOALS	LONG TERM GOALS	INTERVENTION APPROACH	MEASURED BY	REVIEW DATE	PARENTAL APPROVAL	DATE ACHIEVED

Time In: ____________ **Time Out:** ___________

Completed by: ______________________________ Date: ________________

Referring Physician Signature: ____________ Referring Physician Name: __________________Date:______

Facility Physician Signature: ______________ Facility Physician Name:____________________ Date:______