RAWHIDE
Youth and Family Counseling

APPLETON · FOND DU LAC · GREEN BAY · GREATER MILWAUKEE
SHIOCTON · NEW LONDON
E7475 RAWHIDE RD., NEW LONDON, WI 54961-9052
PHONE 1-877-300-9101 FAX (920)531-2686 RAWHIDE.ORG

You are scheduled with _____ on _____ at _____AM / PM

☐ 446 Westhill Blvd., Ste. 6
Appleton, WI 54914

☐ 5555 N Port Washington Rd., Ste. 207
Glendale WI 53217

☐ 916 Willard Dr., Ste. 100
Green Bay, WI 54304

☐ Thompson Center
E7475 Rawhide Rd.
New London, WI 54961

☐ Silver Spring Neighborhood Center
5460 N. 64th St.
Milwaukee, WI 53218

☐ N5367 Mayflower Rd.
Shiocton, WI 54170

☐ W3950 Highway 23
Fond du Lac, WI 54937

☐ School:_____

Payment is due at the time of service for co-pays or session fees.

For sessions not at the New London office

All questions, paperwork, and/or scheduling must go through your counselor or our receptionists at our main office in New London at 877-300-9101.

Please read, complete and sign the following paperwork as indicated.

Minors must have paperwork signed by a parent or legal guardian.

Completed, signed paperwork must be received BEFORE the first session can begin. Your therapist is unable to conduct a session if paperwork is not received.

❑ **CLIENT REGISTRATION FORM** - Fill out completely.

❑ **CLIENT AND FAMILY HISTORY** - Fill out completely.

❑ **INSURANCE INFORMATION -** If applicable, complete the form, then sign and date at the bottom. Bring your insurance card to your first session for us to copy, or return a copy of the **front and back** of the card with your paperwork.

❑ **CLIENT RIGHTS AND THE GRIEVANCE PROCEDURE FOR COMMUNITY SERVICES** & **RIGHTS OF CHILDREN & ADOLESCENTS IN OP MENTAL HEALTH TREATMENT** (as applicable) **-** Read the information on these two disclosures before your first session and keep for your records.

❑ **PSYCHOSOCIAL HISTORY QUESTIONNAIRE** - Fill out completely.

❑ **OUTCOME QUESTIONNAIRE -** Check the box under the category that most accurately describes you or your child in the past seven days. *Select only one category per question and do not leave any unanswered.*

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Children of all ages must be directly supervised by parent or guardian at all times

Clients under age 18

For any client under the age of 18, he or she MUST be accompanied by a legal guardian for the first and second sessions for treatment documentation requirements.

Late Arrivals and No Shows

It is best that you arrive 15 minutes prior to your first appointment to allow time to complete required paperwork. Otherwise, this may result in a delay in seeing your counselor or result in the appointment being rescheduled.

If you are 15 or more minutes late for any follow-up appointments with your counselor, your appointment may be cancelled. You will then need to contact the office to reschedule.

If you do not show or are late for your or your child's appointment and it accumulates to three or more late cancels and/or no shows, you can be involuntarily discharged.

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CLIENT REGISTRATION FORM

Date: _____ Counselor: _____ Referred by: _____

CLIENT INFORMATION

Last Name	First Name	M.I.	Date of Birth	Age	☐ Male ☐ Female

Street	City	State	Zip	County:

SS #: *Email:

Phone: Home ( ) Work ( ) Cell ( )

Religion: Primary Language Spoken: ☐English ☐Spanish ☐Other Marital Status: ☐Minor ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Ethnicity:
☐African-American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other _____

Employed:
☐Full time ☐Part time ☐Unemployed ☐Homemaker ☐Retired ☐Student

Employer:

*Email address for in-house use only. We will never share with any third party.

SPOUSE or LEGAL GUARDIAN(S)

(1) Last Name	First Name	M.I.	SS#	DOB	Age

Street	City	State	Zip

Phone: Home ( ) Work ( ) Cell ( )

Check One:
☐ Spouse ☐ Mother ☐ Father ☐ Other_____

Marital Status:
☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employed:
☐Full time ☐Part time ☐Unemployed ☐Homemaker ☐Retired ☐Student

Employer:

(2) Last Name	First Name	M.I.	SS#	DOB	Age

Street	City	State	Zip

Phone: Home ( ) Work ( ) Cell ( )

Check One:
☐ Mother ☐ Father ☐ Other _____

Marital Status:
☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employed:
☐Full time ☐Part time ☐Unemployed ☐Homemaker ☐Retired ☐Student

Employer:

CHILDREN or SIBLINGS (First & Last Name)	Age	DOB	M/F	Live with mom, dad, both, other

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INSURANCE INFORMATION

Form must be fully completed. Do not just sign and date!

Client: Last Name First Name M.I.

PRIMARY INSURANCE COVERAGE

Policy Holder: Last Name	First Name	M.I.	Date of Birth	☐ Male ☐ Female
SS#:	Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____			
Street	City		State	Zip
Phone: Home ( )	Work ( )	Cell ( )		
Employer:				
Ins. Co. Name:	Ins. Co. Phone#:			
Claims Address:				
Member/ID#:	Group#:			

SECONDARY INSURANCE COVERAGE (if applicable)

Policy Holder: Last Name	First Name	M.I.	Date of Birth	☐ Male ☐ Female
SS#:	Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____			
Street	City		State	Zip
Phone: Home ( )	Work ( )	Cell ( )		
Employer:				
Ins. Co. Name:	Ins. Co. Phone#:			
Claims Address:				
Member/ID#:	Group#:			

CLIENT OR AUTHORIZED PERSON'S SIGNATURE:

I authorize payment of medical benefits to Rawhide Youth & Family Counseling/Rawhide, Inc. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I further authorize the release of any medical or other information necessary to process this claim or any future claims.

Signed: _____ Date: _____

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Client and Family History

Client Name: _____

What is your primary concern today (or with your child)?_____

What do you think caused this problem(s)?_____

When did it start? _____ How severe is it? ☐ Mild ☐ Moderate ☐ Severe

What worries you most about the problem? _____

What results do you hope to see from treatment? _____

Please list 3 things you (or your child) would like to change during treatment:

1. _____
2. _____
3. _____

Have you (or your child) received any of the following? (Use back side if additional space is needed.)
Please circle:
mental health counseling school counseling hospitalization psychological testing psychiatric services

Dates: _____ Provider Name:_____ Issue Treated: _____

Dates: _____ Provider Name:_____ Issue Treated: _____

Drug or Alcohol Rehabilitation ☐ No ☐ Yes Dates: _____ Where? _____

Issue(s) Treated: _____

Please list all medications you (or your child) are taking including prescriptions, over-the-counter, herbals, vitamins, or suspected illegal drugs (please use back side if additional space is needed) :

Name of Medication	Dosage	Dosage Frequency	Prescribing Doctor	Date Medication Started

Has the client ever experienced a seizure? (also known as a "fit' or "convulsion") ☐ No ☐ Yes

If yes, what type of seizure(s)? _____ Age of onset:_____

Treatment received: _____

Has the client ever experienced a serious head injury? (resulting from accident, fight, fall, sports, etc.)

☐ No ☐ Yes Date(s) of injury: _____ Loss of consciousness? ☐ No ☐ Yes

Description of injury: _____

If client is under 18 years old:

Who has parental rights of the child? ☐ Mother ☐ Father ☐ Guardian (relationship): _____

Has either biological mom or dad had parental rights terminated or suspended? ☐ No ☐Yes

If yes, when? _____

Is the child adopted? ☐ No ☐ Yes If yes, at what age was the child adopted?_____

Child's current living arrangements: _____

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Psychosocial History Questionnaire – Minor

Instructions: The information in this form is very important to your counselor, who will be reviewing it with you. It is also very important to the success of your treatment that your counselor understands as much about you as possible. If English is not your primary language, or if you have any vision, reading or writing problems, which might make filling out this form more difficult, please tell a staff member, who will arrange for someone to help you. Please answer the questions as honestly as you can, and feel free to explain or add any other information. If a question does not apply to you or your situation, please write "N/A" in that area of the form. This information, like all other information you give us is confidential.

Client Name: _____Date: _____

Information supplied by: _____Relationship: _____

Developmental History

Pregnancy/Delivery: [briefly describe child's prenatal environment/development]

Duration of pregnancy: _____ weeks

Smoking during pregnancy: □ no □ yes amount _____
Alcohol during pregnancy: □ no □ yes amount/type _____
Drugs during pregnancy: □ no □ yes amount/type _____
Medications during pregnancy: □ no □ yes details _____

Complications during pregnancy or labor: _____
_____

Labor: □ spontaneous □ induced Duration: _____ hours

Delivery type: □ breech □ normal □ Cesarean

Premature: □ no □ yes Weight: _____

Infant days in the hospital: _____

APGAR: _____

Milestones: [briefly describe growth and development concerns]

Motor Skills:
□ delayed □ on target □advanced
Language Development:
□delayed □ on target □advanced
Social Skills:
□delayed □ on target □advanced

Please describe any delays in development: _____
_____

Problems during infancy/early childhood: _____
_____

Medical History:

Childhood illnesses/disorders: [check all that apply, include date/age of onset]

□ Allergies	□ Epilepsy	□ Rheumatic Fever	□ Vision problems
□ Anemia	□ Ear Infections	□ Scarlet Fever	□ Whooping cough
□ Asthma	□ Measles	□ Tonsillitis	□ Other
□ Bed Wetting	□ Mononucleosis	□ Tuberculosis	_____
□ Chicken Pox	□ Mumps	□ Toothache	
□ Diabetes	□ Pneumonia	□ Thyroid problems	

Allergies: Please describe each allergy, the reaction and the treatment needed

_____

_____

Surgeries/Operations: [Describe and continue on back of sheet if more space is needed]

Surgery/operation	Date	Number of days in hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family/Social

Family History:

Mother's Name: _____ Age: _____
(Last) (First) (M.I.) (Maiden)

Educational Level: _____ Occupation: _____

Father: _____ Age: _____
(Last) (First) (M.I.)

Educational Level: _____ Occupation: _____

Parents: □ Married □ Never Married □ Separated □ Divorced: Year _____

Mother remarried: □ Yes □ No Father remarried: □ Yes □ No

Family History of:

Substance Abuse:	□ no	□ yes	details _____
Mental Illness:	□ no	□ yes	details _____
Suicide:	□ no	□ yes	details _____
Violence:	□ no	□ yes	details _____

Cultural/Religious

Ethnic/Cultural background of child: _____

Religious – Spiritual Issues:

Desire to pursue counseling from a Christian perspective? □ Yes □ No

Church affiliation: _____ Attendance: □ Regular □ Occasional

Educational

Client Educational History: [Check all that apply]

□ Infant Day Care □ Pre-School □ Kindergarten
□ Elementary (Current Grade/School: _____)
□ Middle School (Current Grade/School: _____)
□ High School (Current Grade/School: _____)

Official School Classification: [Check one or more]

□ Good Student □ **Learning Disabilities:** □ Extracurricular Activities:
□ Average Student □ *LD or ADHD* □ *ED* _____
□ Poor Student □ *CD* □ *Visually Impaired* □ Sports:
□ *Other:* □ *Hearing Impaired* _____

Strengths:_____ Weaknesses: _____

Type of Placement: [check one or more]

□ Special Education □ Regular classes □ Honors classes (G & T) □ Advanced Classes □ Home Study

Attitudes toward school: [check one or more]

□ Truancy	□ Argumentative	□ Fighting with Peers
□ Poor Effort	□ Disruptive	□ Attentive
□ Repeated Grades	□ Expulsions	□ Suspensions
□ Drugs/ETOH	□ Difficulty with Peers	□ Performance Problems

Describe any behavior problems, suspensions, or expulsions:

_____

_____

Occupational

Client Occupational Status:

□ Employed full-time □ Employed part-time □ Student only

Current employer: _____

Position: _____

Job satisfaction: _____

Future career aspirations: _____

Relationship

Check box if not applicable due to client's age □

Current relationship status: _____

Satisfaction in relationship (if apply): _____

Past significant relationships: _____

Sexual orientation: □ Heterosexual □ Homosexual □ Bisexual □ Unsure

Family Legal History

Client Legal History

Is the client involved in any active cases (traffic, civil, criminal)? □ No □ Yes
If yes, please describe and indicate the court and hearing/trial dates and charges:

Charges	Date Hearing	Date Trial	Where (City,State)	Results [Convicted; Jail/Prison; Probation/Parole; Juvenile Detention]

[Please continue on back of sheet if more space is needed]

Parole Officer _____ Phone: _____

Probation Officer: _____ Phone: _____

DJS Involvement: _____

DJS Worker _____ Phone: _____

Parents Legal History [Indicate Mom or Dad]

Charges	Date Hearing	Date Trial	Where (City,State)	Results [Convicted; Jail/Prison; Probation/Parole; Juvenile Detention]

[Please continue on back of sheet if more space is needed]

Parole Officer: _____ Phone: _____

Probation Officer: _____ Phone: _____