Date:_____

## APPS MENTAL HEALTH
## NEW CLIENT QUESTIONNAIRE (Child/Adolescent)

Child's Name: _____
DOB: _____ SS#_____-_____-_____ Gender M F Unspecified
School: _____ Grade_____IEP OR 504
If Special Education, please specify: _____
Address: _____
City:_____ State:_____ Zip: _____
Home Phone _____ May we leave a message at this number? Y N
Parent's Work Phone _____May we leave a message at this number? Y N
Parent's Cell Phone _____May we leave a message at this number? Y N
Parent's Primary Email: _____May we contact you via email? Y N
Secondary e-mail_____May we send text reminders or messages? Y N
Legal Guardian's Name & DOB (if applicable): _____DOB_____
Mothers Name_____DOB_____ Mothers Occupation _____
Mothers Employer_____ Fathers Name _____DOB _____
Fathers Occupation_____ Fathers Employer_____
BOTH Parents Marital Status ( married, re-married, divorced, separated, never married) Who does child live with
describe time and with whom? _____ Custody Documentation? Y or N
Primary Care Doctor Name:_____ Phone#_____ Fax# _____
Address:_____ Date of Last Office Visit:_____
Referred By:_____ Phone#_____
Optional - Ethnicity:_____Race:_____ Religion:_____ Language_____ Gender_____
**Emergency Contact:**_____ Phone_____Relation_____
I give permission to speak with _____ in an emergency, at my provider's discretion.
**Therapist name:**_____**Phone-**_____**Fax#**_____
**How often are therapy appointments?**_____**Please Sign Release Y or N**
**Any other support persons with child? Y N If yes who?**_____

**INSURANCE INFORMATION:**

Primary Insurance Carrier: _____
ID#_____ Group#_____ Insurance Holder name:_____
Relation:_____ Insurance Holder Date of Birth:_____Active Date _____
SSN of policy holder:___-_____-_____Address of primary insurance holder:_____
Name of Behavioral Health Insurance:_____Phone#_____
Do you have a copay? $_____ Do you have a deductible?$_____ Have you met the deductible? Y or No
Do you need a Referral for full coverage? Y or N Send Claims to Address:_____
Secondary Primary Insurance Carrier:

_____
ID#_____ Group#_____ Insurance Holder name:_____
Relation:_____ Insurance Holder Date of Birth:_____Active Date _____
SSN of policy holder:___-_____-_____Address of primary insurance holder:_____
Name of Behavioral Health Insurance:_____Phone#_____
Do you have a copay? $_____ Do you have a deductible?$_____ Have you met the deductible? Y or No
Do you need a Referral for full coverage? Y or N- Send Claims to Address:_____

_____ _____
Signature Date

_____
Printed Name

Patient Name _____ Date of Birth_____

Your signature below indicates that you have **read and understood** the information in this clinician and patient agreement, and agree to abide by **all** terms indicated in the document during our professional relationship. As well as CRISP acknowledgment.

_____ _____

Client/Responsible Party Signature Printed Name Date

_____ _____

Client/Responsible Party Signature Printed Name Date

Address for billing and or office correspondence:
(This authorizes me to send identifying information to this address)

_____

_____

_____

Phone Number(s) for Office Contact

_____

(This authorizes my office to contact you at this/these number(s). Messages will indicate a first name of the caller and a number for return contacts from you. Please do not include numbers where you prefer not to be contacted or have messages left for you.)

_____ _____

Email address Cell phone number

Appointment reminders are made in the form of text, email or telephone calls. **Please be advised that NO email or text messaging correspondence is considered confidential and may be recovered by other parties at any time. You may lose your right to confidentiality by corresponding with me by email and by receiving correspondence from me by email.**

_____

**Your signature above indicates your approval of receiving email and/or cell phone text messaging from me, knowing the limits of confidentiality.**

PATIENT NAME _____ DATE OF BIRTH _____ DATE _____

***** PLEASE BE SURE TO FILL OUT A RELEASE FOR EACH MEDICAL PROFESSIONAL & THERAPIST THAT YOU HAVE HAD TREATMENT WITH. ALSO, ANY HOSPITAL YOU HAVE BEEN ADMITTED TO OR RECEIVED TREATMENT:***

## ***CURRENT MEDICATIONS:***

| NAME OF MEDICATION | DOSE (mg) | FREQUENCY | PRESCRIBED BY | DIAGNOSIS | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**PREVIOUS HOSPITALIZATIONS**: ( NAME OF HOSPITAL--REASON FOR ADMISSION & ADMISSION DAYS) _____

PAST MENTAL HEALTH MEDICATIONS( APPROX DATES MEDICATION WAS TAKEN AND WHY STOPPED)_____

ALLERGIES TO MEDICATIONS( AND REACTION)-_____

**CONSENT FOR RELEASE OF INFORMATION**
**CB Benway, CRNP, PMH**
**201 Prospect Ave**
**Hagerstown, Maryland 21742**
**appsmentalhealth@gmail.com**
**Telephone: 240-970-7300 *Fax: 240-231-9755**

**INFORMED CONSENT FOR ONLINE THERAPY/ MEDICATION MANAGEMENT SERVICES**

This form is designed to allow you to give informed consent for the use of video technology for online therapy and medication management. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

I understand that therapy and medication management conducted online is technical in nature and that problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/ or services supplied by a 3rd party may result in interruptions. Any problems with internet availability or connectivity are outside the control of the provider and the provider makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session can not be completed via online video conferencing, I agree to call my provider back at 240-970-7300 (office telephone number). Immediately. Or other arrangements will be made.

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER OR DEVICE AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my User ID to access these services. I also understand that there will be no recording of any of the online or telephone sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

| | | |
|---|---|---|
| Patient/ Client Signature | Printed Name | DATE |
| Parent, Guardian/ Legal Representative Signature | Printed Name | DATE |
| Provider Signature or Witness Signature | Printed Name | DATE |

8-17 years old

Name: Date:

ID#: DOB.

## GAD-7

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | **Not At All** | **Several Days** | **More Than Half the Days** | **Nearly Every Day** |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 ○ | 1 ○ | 2 ○ | 3 ○ |
| 2. Not being able to stop or control worrying | 0 ○ | 1 ○ | 2 ○ | 3 ○ |
| 3. Worrying too much about different things | 0 ○ | 1 ○ | 2 ○ | 3 ○ |
| 4. Trouble relaxing | 0 ○ | 1 ○ | 2 ○ | 3 ○ |
| 5. Being so restless that it is hard to sit still | 0 ○ | 1 ○ | 2 ○ | 3 ○ |
| 6. Becoming easily annoyed or irritable | 0 ○ | 1 ○ | 2 ○ | 3 ○ |
| 7. Feeling afraid as if something awful might happen | 0 ○ | 1 ○ | 2 ○ | 3 ○ |

**(For office coding: Total Score** ☐ + ☐ + ☐ = ☐ **)**

ADDRESSING Mental Health CONCERNS IN PRIMARY CARE
A CLINICIAN'S TOOLKIT

8-17 years old

**PHQ-9: MODIFIED FOR TEENS**

# PHQ-9: Modified for Teens

ID#:

DOB:

Name

Clinician

Date 9/22/2021

**Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom, choose the answer that best describes how you have been feeling.**

| | (0) Not At All | (1) Several Days | (2) More Than Half the Days | (3) Nearly Every Day |
|---|---|---|---|---|
| 1. Feeling down, depressed, irritable, or hopeless? | ○ | ○ | ○ | ○ |
| 2. Little interest or pleasure in doing things? | ○ | ○ | ○ | ○ |
| 3. Trouble falling asleep, staying asleep, or sleeping too much? | ○ | ○ | ○ | ○ |
| 4. Poor appetite, weight loss, or overeating? | ○ | ○ | ○ | ○ |
| 5. Feeling tired, or having little energy? | ○ | ○ | ○ | ○ |
| 6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down? | ○ | ○ | ○ | ○ |
| 7. Trouble concentrating on things like school work, reading, or watching TV? | ○ | ○ | ○ | ○ |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual? | ○ | ○ | ○ | ○ |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way? | ○ | ○ | ○ | ○ |

In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ○ Yes ○ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

○ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ○ Yes ○ No

Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ○ Yes ○ No

For Office Use Only **Score**



American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

PATIENT NAME ( LAST, FIRST) (DOB) (DATE) 14-17 years

# The CRAFFT Screening Interview

Patient ID:
Date:

**Begin**: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

## Part A

**During the PAST 12 MONTHS, did you**

1. **Drink** any **alcohol** (more than a few sips)? (Do not count a few sips of alcohol taken during family or religious events) ○ No ○ Yes
2. **Smoke** any **marijuana** or **hashish**? ○ No ○ Yes
3. **Use anything else** to get high? ("**anything else**" includes other illegal drugs, prescription or non-prescription medicines or things that people sniff or "huff") ○ No ○ Yes

**For clinic use only: Did the patient answer "yes" to any questions in Part A?**

○ No → **Ask CAR question only, then stop**

○ Yes → **Ask all 6 CRAFFT questions**

## Part B

1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs? ○ No ○ Yes
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in? ○ No ○ Yes
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE?** ○ No ○ Yes
4. Do you ever **FORGET** things you did while using alcohol or drugs? ○ No ○ Yes
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use? ○ No ○ Yes
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs? ○ No ○ Yes

*Two or more YES answers on the CRAFFT suggest a serious problem and need for further assessment.

TOTAL

# Adverse Childhood Experience (ACE) Questionnaire

## Finding your ACE Score

5-100 years

ID# _____ DOB _____

Name _____ Date _____

**While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   **or**
   Act in a way that made you afraid that you might be physically hurt?
   ○ Yes ○ No _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   **or**
   **Ever** hit you so hard that you had marks or were injured?
   ○ Yes ○ No _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   **or**
   Try to or actually have oral, anal, or vaginal sex with you?
   ○ Yes ○ No _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   **or**
   Your family didn't look out for each other, feel close to each other, or support each other?
   ○ Yes ○ No _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   **or**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ○ Yes ○ No _____

6. Were your parents **ever** separated or divorced
   ○ Yes ○ No _____

7. Was your mother or stepmother:
   **Often** pushed, grabbed, slapped, or had something thrown at her?
   **or**
   **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?
   **or**
   **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   ○ Yes ○ No _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ○ Yes ○ No _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   ○ Yes ○ No _____

10. Did a household member go to prison?
    ○ Yes ○ No _____

_____ **This is your ACE Score**

**CONSENT FOR RELEASE OF INFORMATION**
**ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC**

**CB Benway CRNP, PMH, Owner**
**13327 Wisdom Way**
**Hagerstown, Maryland 21742**
**appsmentalhealth@gmail.com**
**Telephone: 240-970-7300 Fax: 240-231-9755**

---

I, _____ Date of Birth_____
(Clients Name) (Date of Birth)

hereby authorize the exchange of information between:

_____
(Full name of person or provider you wish us to contact or exchange information with or get information from)

_____

(Their address, phone fax, and e-mail if you have it)

_____
and CB Benway CRNP, PMH, owner as well as staff and providers of ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC. This may include: (Specify records, reports, verbal conversations, all records or other data to be released).
( ALL RECORDS, EVALUATIONS, RESULTS AND VERBAL CONVERSATIONS)_____

_____

_____
The records are required for the specific purpose of ( continuity of care, a continuation of care, collaboration of care, transfer of care, records).
_CONTINUITY OF CARE COLLABORATION OF CARE _____

_____
I understand that my authorization shall remain effective for a period of one year from the date of my signature and that all information released will be handled confidentially, in compliance with the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 92-282), and the Maryland Mental Health Code HG §8-601.
I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written dated communication to CB Benway CRNP, PMH, Owner, as well as staff and providers of & Advanced Practice Psychiatric Solutions, LLC.
It is agreed that the recipient of this information will refrain from and will protect against disclosure of any information received which is not authorized by further consent of the patient of his/her parent, guardian, or authorized representative unless provided for under law or regulation.
I understand that I may not be required to sign this authorization as a condition of my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____
Clients Signature Parent or Legal Guardian

_____ _____
Witness Date

**CONSENT FOR RELEASE OF INFORMATION**
**ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC**

**CB Benway CRNP, PMH, Owner**
**13327 Wisdom Way**
**Hagerstown, Maryland 21742**
**appsmentalhealth@gmail.com**
**Telephone: 240-970-7300 Fax: 240-231-9755**

---

I, _____ Date of Birth_____
(Clients Name) (Date of Birth)

hereby authorize the exchange of information between:

_____
(Full name of person or provider you wish us to contact or exchange information with or get information from)

_____

(Their address, phone fax, and e-mail if you have it)

_____
and CB Benway CRNP, PMH, owner as well as staff and providers of ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC. This may include: (Specify records, reports, verbal conversations, all records or other data to be released).
( ALL RECORDS, EVALUATIONS, RESULTS AND VERBAL CONVERSATIONS)_____

_____

_____
The records are required for the specific purpose of ( continuity of care, a continuation of care, collaboration of care, transfer of care, records).
_CONTINUITY OF CARE COLLABORATION OF CARE _____

_____
I understand that my authorization shall remain effective for a period of one year from the date of my signature and that all information released will be handled confidentially, in compliance with the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 92-282), and the Maryland Mental Health Code HG §8-601.
I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written dated communication to CB Benway CRNP, PMH, Owner, as well as staff and providers of & Advanced Practice Psychiatric Solutions, LLC.
It is agreed that the recipient of this information will refrain from and will protect against disclosure of any information received which is not authorized by further consent of the patient of his/her parent, guardian, or authorized representative unless provided for under law or regulation.
I understand that I may not be required to sign this authorization as a condition of my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____
Clients Signature Parent or Legal Guardian

_____ _____
Witness Date

**CONSENT FOR RELEASE OF INFORMATION**
**ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC**

**CB Benway CRNP, PMH, Owner**
**13327 Wisdom Way**
**Hagerstown, Maryland 21742**
**appsmentalhealth@gmail.com**
**Telephone: 240-970-7300 Fax: 240-231-9755**

---

I, _____ Date of Birth_____
(Clients Name) (Date of Birth)

hereby authorize the exchange of information between:

_____
(Full name of person or provider you wish us to contact or exchange information with or get information from)

_____
(Their address, phone fax, and e-mail if you have it)

_____
and CB Benway CRNP, PMH, owner as well as staff and providers of ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC. This may include: (Specify records, reports, verbal conversations, all records or other data to be released).
( ALL RECORDS, EVALUATIONS, RESULTS AND VERBAL CONVERSATIONS)_____

_____

_____
The records are required for the specific purpose of ( continuity of care, a continuation of care, collaboration of care, transfer of care, records).
_CONTINUITY OF CARE COLLABORATION OF CARE _____

_____
I understand that my authorization shall remain effective for a period of one year from the date of my signature and that all information released will be handled confidentially, in compliance with the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 92-282), and the Maryland Mental Health Code HG §8-601.
I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written dated communication to CB Benway CRNP, PMH, Owner, as well as staff and providers of & Advanced Practice Psychiatric Solutions, LLC.
It is agreed that the recipient of this information will refrain from and will protect against disclosure of any information received which is not authorized by further consent of the patient of his/her parent, guardian, or authorized representative unless provided for under law or regulation.
I understand that I may not be required to sign this authorization as a condition of my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____
Clients Signature Parent or Legal Guardian

_____ _____
Witness Date

# CONSENT FOR RELEASE OF INFORMATION
# ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC

**CB Benway CRNP, PMH, Owner**
**13327 Wisdom Way**
**Hagerstown, Maryland 21742**
**appsmentalhealth@gmail.com**
**Telephone: 240-970-7300 Fax: 240-231-9755**

---

I, _____ Date of Birth_____
(Clients Name) (Date of Birth)

hereby authorize the exchange of information between:

_____
(Full name of person or provider you wish us to contact or exchange information with or get information from)

_____

(Their address, phone fax, and e-mail if you have it)

_____

and CB Benway CRNP, PMH, owner as well as staff and providers of ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC. This may include: (Specify records, reports, verbal conversations, all records or other data to be released).

_____
_____
_____

The records are required for the specific purpose of ( continuity of care, a continuation of care, collaboration of care, transfer of care, records).

_____
_____

I understand that my authorization shall remain effective for a period of one year from the date of my signature and that all information released will be handled confidentially, in compliance with the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 92-282), and the Maryland Mental Health Code HG §8-601.

I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written dated communication to CB Benway CRNP, PMH, Owner, as well as staff and providers of & Advanced Practice Psychiatric Solutions, LLC. It is agreed that the recipient of this information will refrain from and will protect against disclosure of any information received which is not authorized by further consent of the patient of his/her parent, guardian, or authorized representative unless provided for under law or regulation.

I understand that I may not be required to sign this authorization as a condition of my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____
Clients Signature Parent or Legal Guardian

_____ _____
Witness Date

1-11 years old

**Advanced Practice Psychiatric Solutions, LLC**
13327 Wisdom Way
Hagerstown, MD 21742
Office: (240) 970-7300
Fax: (240) 231-9755
appsmentalhealth@gmail.com
NPI 1679053540

## Delegation of Authority Consent for Treatment

I _____, certify that I am the parent or legal guardian of
_____ Date of Birth_____.
(NAME OF CHILD)

I Hereby delegate to the following individual ("Designee") the authority to consent for any and all medical/ mental health treatment provided by Advanced Practice Psychiatric Solutions, LLC for the above-named child.

NAME OF DESIGNEE _____

ADDRESS OF DESIGNEE_____

_____.

PHONE NUMBER:_____-_____-_____

FAX NUMBER:_____-_____-_____

EMAIL ADDRESS:_____

This authority includes, but is not limited to, the following methods of treatment:

Physical Health assessment
Prescription of specific medications
Physical health assessment
Psychotherapy- individual group or and family
Art therapy
Speech and Language Therapy

I further authorize Advanced Practice Psychiatric Solutions, LLC, to release medical record information about the above-named child to my Designee.

I understand that this delegation of authority shall remain in effect until it is revoked by me or my Designee, in writing, AND a copy of such revocation is received by Advanced Practice Psychiatric Solutions, LLC

I release Advanced Practice Psychiatric Solutions, LLC and their directors, officers, employees and agents from any claims or liability arising solely out of their reliance upon this delegation of authority

_____ _____

(SIGNATURE OF PARENT/GUARDIAN) (DATE)

_____ _____

(WITNESS SIGNATURE) (DATE)

I HEREBY ACCEPT THE ABOVE-REFERENCED DELEGATION OF AUTHORITY TO CONSENT FOR TREATMENT.

_____ _____

(SIGNATURE OF DESIGNEE) (DATE)