TriCity Family Services

CLIENT APPLICATION

General Info

Client Name: _____ Date: _____

Address: _____ Home #: (___)_____ Cell #: (___)_____

City, State, Zip: _____ Work #: _____

Present Household/Family

Options: Married, Single, Co-habiting, Separated, Divorced, Widowed

Options: White, African American, Hispanic, Native American, Asian, Other

Full Name (no nicknames)	Birth Date Mo/Day/Yr	Relationship to You	Marital Status	Education Level	Race/ Ethnicity	Living at home? (Yes or No)
		Self/Client				

If client is under the age of 18, please provide mother's maiden name: _____

May we call to remind you of upcoming appointments? ☐ Yes ☐ No
If yes, at what telephone number? (___)_____

Personal Profile

- Do you speak English? ☐ Yes ☐ No If no, what language do you speak? _____

Emergency Contact Person: _____
Address: _____
_____
Phone #: _____

Child under DCFS Guardianship: _____
Foster Parents: _____
Address: _____
_____
Phone #: _____

IDCFS Case Worker: _____
Address: _____
_____
Phone #: _____

PLEASE COMPLETE REVERSE SIDE ⇒

Please complete the following information if you will be using commercial insurance, ALL KIDS or wish to apply for our sliding fee scale. If you do not wish to complete this information, you will be responsible for paying the full fee.

Income #1 (Yourself)

Annual Gross Income $_____

Income #2 (Spouse/Partner)

Annual Gross Income $_____

Additional income

Such as part time employment, second job, public aid, unemployment, child support, interest, other:

Type: _____ Annual Total: $_____

Type: _____ Annual Total: $_____

TOTAL ANNUAL HOUSEHOLD INCOME: $_____

FOR OFFICE USE ONLY

Attestation of Consumer Monthly Income

Consumer Name: _____
Last First Middle

RIN: _____ Household Size: _____ persons

Gross Monthly Household Income: $_____

Source: _____

D = Document (pay stub, tax form, etc.)
C = Consumer attestation
G = Consumer parent or guardian attestation
P = Provider attestation

Signature: _____ Date: _____

A. Have you sought help in obtaining any of the following services:

- ☐ Substance Abuse Treatment
- ☐ MH Case Management
- ☐ Hospitalization
- ☐ Other _____
- ☐ Unknown
- ☐ Not Applicable
- ☐ Residential/Living Arrangements
- ☐ Vocational Rehabilitation
- ☐ Transportation
- ☐ Medical

B. Please file claims to my insurance company according to the information I have provided below:

Employee _____

Soc. Security # and/or ID# _____ Group #_____

Name of Insurance Company _____

Insurance Company Phone # _____

Insurance Company Address _____

City: _____ State: _____ Zip: _____

The insured or authorized person's signature is required if you are using your insurance benefits for:

1. The release of any medical or other information necessary to process this claim.
2. The payment of medical benefits to TriCity Family Services who accepts assignment for its services.

SIGNED _____ DATE _____

C. Please answer the following questions:

1. If the client is under 18, do they currently have an ALL KIDS Card? ☐ Yes ☐ No
   If yes, what is the ALL KIDS Number: _____
2. Are you currently enrolled in Medicare? ☐ Yes ☐ No
   If yes, what is your Medicare Number: _____
3. Are you currently applying for or receiving SSI/SSDI?
   ☐ Yes ☐ No
4. Are you currently enrolled in CILA, ACT, DFI? ☐ Yes ☐ No

Please attach a copy of your Insurance/ALL KIDS/Medicare card

TriCity Family Services

CLIENT HISTORY
Counseling Program

Name: _____ Date: _____

What concern(s) brings you to Counseling?

_____

_____

_____

What changes do you want to see as a result of coming to Counseling?

_____

_____

_____

Client's Medical History

Currently under a doctor's care: _____**Yes** _____**No**

Doctor(s) involved in your care: _____

Health problems (include allergies): _____

Medication currently used: ☐ None

Medication	Dosage	Doctor Prescribing	Why Prescribed

Past Hospitalizations - Medical, Psychiatric, Chemical Dependency: None

Date (s)	Reason (s)	Hospital

Previous Counseling, EAP or Chemical Dependency Services: None

Facility/Counselor Name	Date (s)	Reason (s)	Helpful?

Tri-City Family Services

Symptom Checklist

Please complete for each person attending the first appointment.

Client's Name: _____ Date: _____

Person Completing Form: _____

Please check how often these symptoms occurred *in the last 6 months.* If you are a parent completing this form for your child/adolescent, please provide your child's/adolescent's symptoms *in the last six months.*

SYMPTOM	Never or rarely	A few times a month	Nearly every day	SYMPTOM	Never or rarely	A few times a month	Nearly every day
Guilt Feelings				Hopeless about future			
Worrying				Thinking about death			
Too much energy				Thinking about suicide			
Aggressive				Problems with family members			
Uncontrolled temper				Brooding about the past			
Afraid of work/school				Crying excessively			
Afraid of leaving house				Feeling down or sad			
Sleep walking				Nightmares			
Problems falling asleep				Feeling anxious			
Problems staying asleep				Feeling panicky			
Memory loss				Problems with anger			
Trouble making decisions				Feeling jealous			
Feeling alone				Feeling impatient			
Difficulty concentrating				No confidence in self			
Sudden mood changes				Shortness of breath			
Restlessness				Fast heart beat			
Easily Distracted				Chest pains			
Problems getting along				Feelings of unreality			
Feeling worthless				Lying			
Overly tired				Problems at home			
Poor or no appetite				Alcohol use			
Over eating				Drug use			
Bingeing				Blackouts			
Food preoccupation				Stomach Problems			
Vomiting				Uncontrolled thoughts			
Sleeping too much				Uncontrolled behavior			
Hearing voices				Physical abuse of self orothers			
Problems at work/school				Emotional abuse of self or others			
Stealing				Other:			

TriCity Family Services

Family Based Treatment for Eating Disorders

Parent Questionnaire

Date: _____

1. Family Meals

Briefly describe your family's eating style and who prepares these meals:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

How many times a week does your family eat dinner together at the table?

Describe mealtime in your home (discussions/conflicts and general atmosphere of mealtime):

_____

_____

_____

Have there been any changes in mealtime since the eating problems started? If so, please explain:

_____

_____

_____

How many times per week do you go out to eat?_____

Who does the grocery shopping?_____

Is anyone in your family a vegetarian?_____

Are there any other food restrictions your family follows?_____

_____

2. Family Schedules

What are your family's schedules like every day, including work hours and after school activities?

_____

_____

Who is home after school when your child gets home? _____

3. Academic/Social

What is your child's current grade level? _____

What is their academic record like? _____

_____

Does your child have a job outside of school? _____

What have been their best subjects in school or most favored interests/hobbies? _____

_____

Are they involved in sports, music or arts? _____

_____

Would you describe your child as (check all that apply):

☐ Outgoing and social ☐ Introverted/shy, but has friends ☐ Introverted/shy, not many friends

Has there been any difference in your child's social life since the eating problems began? If so, please explain.

_____

_____

Please list three of your child's strengths: _____

_____

4. Family History/Relationships

Please describe any events you consider significant in the family history including potential stressors. (These may include events such as divorce/separation, financial stressors, moving/relocation, death or illness of relatives/close friends, health concerns, traumatic events, etc.):

_____

_____

_____

_____

_____

Please describe your son/daughter prior to the eating problems._____

_____

_____

_____

_____

Describe any changes you have noticed in your son/daughter's eating behavior and body condition/appearance. Please note when you first started to notice these changes.

Have the eating problems changed your relationship with your son/daughter? If so, please explain.

What goals do you have for treatment?

What goals do you think your son/daughter has for treatment?

Please describe ways you have tried to resolve the eating problems on your own, as a family?

What do you think your son/daughter would like to change about you?

Please add any other information you think might be helpful.

TriCity Family Services

1120 Randall Court, Geneva, IL 60134 630.232.1070 Fax: 630.232.1471

Family-Based Treatment (FBT)

MEDICAL CLEARANCE FORM

Name: _____ **DOB:** _____ **Date:** _____

Dear _____:

The patient named above is interested in participating in TriCity Family Services' Family-Based Treatment for Eating Disorders Program (FBT). Clients must be medically stable to participate in outpatient therapy; otherwise a higher level of care is necessary. After examining the patient, please complete the following or attach relevant paperwork and fax to (630) 232-1471.

_____ _____

Signature of FBT Therapist Printed Name of FBT Therapist

Date of Exam: _____

Please Provide A Healthy Weight Range for Client's Height and Weight (Growth Chart)	Weight Range : Between _____ and _____ pounds	
Medications	/Dosage:	/Dosage:
	/Dosage:	/Dosage:
Orthostatic Measures	Supine Blood Pressure:	Standing Blood Pressure:
	Supine Pulse:	Standing Pulse:
Last Menstrual Period	Date:	In the past 6 months has the client missed 3 consecutive periods? ☐ Yes ☐ No
Other Significant Medical Problems		
Abnormal Findings on Medical Exam		

Please attach client growth chart if possible.

The Academy for Eating Disorders (AED) recommends the following tests. Please perform any of the following that you deem necessary:

_____ Complete Blood Count _____ Comprehensive Metabolic Panel _____ TSH
_____ Urinalysis _____ Hormone Panel _____DXA _____ Electrocardiogram

I have examined this patient and certify that he/she is medically stable and able to participate in the Family-Based Treatment for Eating Disorders Program (FBT) at TriCity Family Services.

Signature: _____ **Date:** _____