Informed Consent and Notice of Rights for Psychological Services

(Check one box)

☐ Bring this copy to your appointment ☐ Keep this copy for your records

The care team at the Melrose Center is made up of a multidisciplinary group of professionals dedicated to helping women and men reclaim their lives from eating disorders. Psychotherapy services for the program are provided by licensed psychologists, licensed clinical social workers and licensed marriage and family therapists.

The following information covers many questions that may arise about psychotherapy and includes a listing of client's rights and psychologist's obligations. Any questions not covered should be brought to the attention of your psychologist.

The Bill of Rights for clients obtaining psychological services is posted in the waiting room. This provision is not a legal bill of rights, but a statement of what you can reasonably expect from a therapist.

Clients seeking psychological services have the right to know the following information.

1. Information about the availability of the therapist. Clients are invited to ask when the therapist is available and where to call during off-hours in case of emergency.

2. Information about the structure of the therapeutic relationship. Clients are invited to ask the following.
    - The manner in which the therapist conducts sessions around intake, treatment and termination. Clients may take an active part in their therapeutic process by asking questions about issues relevant to therapy, specifying therapeutic goals and renegotiating goals, when necessary.
    - The perspective(s) the therapist typically uses to structure therapy and treatment methods. Clients may refuse any intervention or treatment strategy. It is essential, however, that therapist and client work together on a mutually agreed-upon treatment plan.
    - The purpose of and risks involved in psychological treatment. Clients have a right to know, for example, that during the process of therapy, emotional pain and distress can arise that may be uncomfortable.
    - The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.
    - The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consulting another therapist.

3. Information about fees and billing arrangements. Clients are invited to inquire about the amount of the fee, the time frame for payment, the method of payment, the access to billing statements and billing for missed appointments and late cancellations.
4. Information about the therapist's status including the therapist's training, credentials and years of experience.
5. Information about informed consent and exceptions to confidentiality. Clients are invited to inquire about the following.
    - The therapist's duty to maintain confidentiality by not releasing information to others unless authorized to do so by the client. Information about your psychotherapy treatment sessions will be discussed with members of your multidisciplinary care team at the Melrose Center to ensure integrated care. Information about your psychotherapy treatment sessions may be disclosed with an outside consultant to ensure quality care.
    - The circumstances under which confidentiality is limited. The therapist's duty is to:
        - warn another in case of potential suicide, homicide or the threat of imminent, serious harm to another individual
        - report knowledge of a child being neglected, physically or sexually abused
        - report knowledge of a vulnerable adult being mistreated
        - report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine and amphetamine or their derivatives
        - report the misconduct of other health care professionals
        - provide to a spouse or the parents of a deceased client access to their child's or spouse's records
        - release records if subpoenaed by the courts
        - provide to parents of minor children (under age 18) access to their children's records. There are situations in which minors can give consent for their own treatment without parental consent. Under these circumstances, the minor alone may authorize release of records. The minor also assumes financial responsibility for health care services when she or he consents to treatment.
        - to release records if subpoenaed by the courts
6. Information about counseling records. Clients are invited to inquire about the following.
    - Record maintenance, including the security and length of time they are kept. Files are stored in a secure, locked location and are kept a minimum of 10 years. For adolescents, records are kept 10 years after the client reaches age 18.
    - Client's right to access personal records.
    - Release policies and procedures.
7. Information about referral questions. Clients are invited to inquire about the client's right to request a referral and the right to require the current therapist to send a written report about services rendered to the qualified referred therapist or organization, upon the client's written authorization.

My signature indicates that I have read this document and have had the opportunity to have my questions answered. I consent to receive psychotherapy services.

Client signature: _____ Date: _____ Time: _____

Parent signature: _____ Date: _____ Time: _____
(if client is a minor)

Support Questionnaire

This is an optional form to help Melrose Center gather additional information about the individual coming in for an Initial Assessment. This form can be filled out by a parent, spouse, friend or other concerned person.

1) Name of person receiving assessment for an eating disorder at Melrose Center?

_____

2) Who is filling out this form and what is your relationship to the person getting an assessment?

_____

3) Please check any of the areas that concern you about this individual:

- ☐ Fights over food or during family meals
- ☐ Restricting, not eating, cutting food into small bits, hiding food
- ☐ Compulsive or excessive exercise; injuries due to this
- ☐ Hiding during meals, fears around eating with others
- ☐ Excessive eating / Binge Eating
- ☐ Purging (vomiting or laxative use)
- ☐ Supplements of any kind: diet pills, protein powders, hormone injections
- ☐ Physical appearance
- ☐ Depression, anxiety, isolation, irritability or other mood changes
- ☐ Compulsive behaviors
- ☐ Self-injurious behavior or suicidal thoughts
- ☐ Difficulty sleeping
- ☐ Alcohol or drug use
- ☐ Lack of resources for basic needs
- ☐ Legal issues
- ☐ Other _____

4) Describe any changes or events in the person's environment (new school, move, job loss, death in family, changes with friends, any changes in their relationships)?

_____

_____

5) Has the individual had significant changes in their academic, social or work performance in the past 6 months?

☐ No ☐ Yes, if yes, please describe: _____

_____

_____

6) Is anyone in the individual's household on a special diet including weight loss programs?

☐ No ☐ Yes, if yes, type of diet and reason for the special diet: _____

7) Has anyone in the family received eating disorder treatment?

☐ No ☐ Yes If yes, who? _____

8) Does anyone in the family have a history of an eating disorder?

☐ No ☐ Yes If yes, when and where? _____

9) Additional comments or concerns? Anything else you want us to know in order to help with our assessment?

Signature of person filling out the form	Printed name	Date

HealthPartners®

Melrose Eating Disorders Child Intake Questionnaire

QUESCSN

1. Please tell us the reason for your child's visit today and what concerns they have.

_____

_____

2. How long has your child been experiencing these concerns? *Check one.*
   ☐ 0-2 Weeks ☐ 2-4 Weeks ☐ 1-3 Months ☐ 3-6 Months
   ☐ 6-12 Months ☐ 1-2 Years ☐ 2-5 Years ☐ Over 5 Years

3. Does your child live in more than one household? ☐ Yes ☐ No

4. Tell us about your child's primary household. Who do they live with? *Check all that apply.*

   ☐ Mother and father
   ☐ Father and spouse/partner
   ☐ Father only
   ☐ Relative guardian
   ☐ Mother and spouse/partner
   ☐ Mother only
   ☐ Foster parent(s)
   ☐ State/Government facility (group home)

   Parent/Caregiver name _____
   Is this above selected individual the legal guardian for your child? ☐ Yes ☐ No

5. Tell us about your child's secondary household (if applicable). Who is part of this household? *Check all that apply.*

   ☐ Mother and father
   ☐ Father and spouse/partner
   ☐ Father only
   ☐ Relative guardian
   ☐ Mother and spouse/partner
   ☐ Mother only
   ☐ Foster parent(s)
   ☐ State/Government facility (group home)

   Parent/Caregiver name _____
   Is this above selected individual the legal guardian for your child? ☐ Yes ☐ No

6. Are there currently any custody arrangements in place for your child? ☐ Yes ☐ No
   Provide the following information on the non-custodial parent if not previously listed in household questions:
   Name _____ Age _____

   Location _____

   Describe any visitation schedules that are in place and please bring a copy of the custody order to your next appointment.

   _____

   _____

7. Is your child adopted? ☐ Yes ☐ No
   If yes, do they know about the adoption? ☐ Yes ☐ No
   How old were they at the time of the adoption? _____

8. List any important relationships your child might have. *Examples include parents, siblings, friends, etc.*

   _____

   _____

9. How supportive are these relationships? *Check one.*

   ☐ Very supportive ☐ Somewhat supportive ☐ A little supportive ☐ Not supportive at all

10. What is the preferred language spoken by parents and/or caregivers in the household?

    _____

11. Have there been any major changes or stresses in your child's life? *Check all that apply.*

    ☐ Financial stress
    ☐ Caregiver unemployment, financial stress
    ☐ Marital, relationship stress, significant caregiver arguing
    ☐ Divorce, visitation, post-divorce conflict or problems
    ☐ Other
    ☐ Harassment or discrimination
    ☐ Sibling with special needs
    ☐ Parent with chronic illness
    ☐ New step-parent or step-sibling
    ☐ Loss of a loved one
    ☐ Move or change in home
    ☐ Move or change in school
    ☐ None

    If Other, please describe _____
    Are any of these currently occurring? If so, explain:_____

12. Has your child ever experienced or seen any of the following traumatic events? *Check all that apply.*

    ☐ Violence/domestic violence
    ☐ Natural disaster
    ☐ Harassed or bullied
    ☐ Separation from caregiver(s)
    ☐ Out of home placement
    ☐ Other
    ☐ Physical, sexual, or emotional abuse
    ☐ Car accident
    ☐ Homelessness
    ☐ Not having enough food
    ☐ None

    If Other, please describe _____

    Are any of these currently occurring? If so, explain:_____

13. Have you or your child been involved with any of the following county resources? *Check all that apply.*

    ☐ PCA (Personal Care Assistant)
    ☐ County Social Worker
    ☐ PACER (Parent Advocacy Coalition for Educational Rights)
    ☐ Developmental disorder social worker
    ☐ Other
    ☐ Foster care
    ☐ Respite care
    ☐ The ARC
    ☐ None

    If Other, please describe _____

14. Has your child had any of the following involvement with the legal system? *Check all that apply.*

- ☐ Child Protective Services (CPS)
- ☐ Legal charges
- ☐ Probation
- ☐ Other
  If Other, please describe _____
- ☐ Court ordered treatment
- ☐ Parole
- ☐ None

Tell us a little about your child's weight:

15. Highest weight _____ Age at highest weight _____

    Lowest weight _____ Age at lowest weight _____

16. Does your child have difficulty gaining weight? ☐ Yes ☐ No

17. Have there been past or present nutritional concerns with your child? ☐ Yes ☐ No

18. Has it been difficult for your child to eat at family functions, restaurants, or birthday parties?
    ☐ Yes ☐ No

19. Please list any foods your child avoids.

_____

_____

20. What eating-related symptoms or behaviors does your child currently experience? *Check all that apply.*

- ☐ Overeating/emotional eating/binge eating
- ☐ Laxative use
- ☐ Excessively picky eater
- ☐ Purging (self-induced vomiting)
- ☐ Choking or vomiting phobia
- ☐ Restricting food/under weight
- ☐ Compulsive or excessive exercise
- ☐ Hiding food
- ☐ Diet pills/supplements or weight loss programs

21. What eating-related symptoms or behaviors has your child experienced? *Check all that apply.*

- ☐ Overeating/emotional eating/binge eating
- ☐ Laxative use
- ☐ Excessively picky eater
- ☐ Purging (self-induced vomiting)
- ☐ Choking or vomiting phobia
- ☐ Restricting food/under weight
- ☐ Compulsive or excessive exercise
- ☐ Hiding food
- ☐ Diet pills/supplements or weight loss programs

Tell us a little about the pregnancy with this child

22. Were there any problems or complications? ☐ Yes ☐ No ☐ Unknown

23. Were any medications taken besides vitamins? ☐ Yes ☐ No ☐ Unknown

24. Was alcohol used? ☐ Yes ☐ No ☐ Unknown

25. Were street drugs used? ☐ Yes ☐ No ☐ Unknown

26. What was the length of pregnancy, in weeks? _____

27. What was the weight at delivery, in pounds? _____

28. What was the mother's age? _____

29. What was the father's age? _____

30. Were there complications during delivery? ☐ Yes ☐ No

31. Were there any complications during the first 24 hours after delivery? ☐ Yes ☐ No

Tell us about your child's schooling
If you are unsure of the answers to the following questions, please bring any necessary information to the visit.

32. What grade are they currently in? _____

33. Name of current school they are attending _____

34. Did they attend a pre-school program? ☐ Yes ☐ No

35. Did they attend summer school? ☐ Yes ☐ No

36. Have they ever repeated a grade? ☐ Yes ☐ No

37. Have they had a Special Education evaluation? ☐ Yes ☐ No

38. Does your child have any history of medical problems? ☐ Yes ☐ No
If yes, please describe _____

39. Date of your child's last bowel movement: _____

40. In the last 3 months, has your child experienced any of the following related to medical concerns?
Check all that apply

- ☐ Lightheadedness or dizziness
- ☐ Chest pain or irregular heartbeat
- ☐ Muscle cramps
- ☐ Chronic pain
- ☐ Stomach problems
- ☐ Vomiting blood
- ☐ Seizures
- ☐ Other

If Other, please describe _____

- ☐ Fainting
- ☐ Sensitivity to cold or change to skin color
- ☐ Shortness of breath
- ☐ Diarrhea or constipation
- ☐ Trouble swallowing, heartburn, or reflux
- ☐ Headaches
- ☐ None

41. In the last 3 months, has your child experienced any of the following related to mood concerns?
Check all that apply

- ☐ Depressed mood or unhappy
- ☐ Appetite or weight changes
- ☐ Impulsive behaviors
- ☐ Fatigue
- ☐ Problems concentrating or problems making decisions
- ☐ Self-harm
- ☐ Other

If Other, please describe _____

- ☐ Little interest or pleasure in most activities
- ☐ Trouble falling asleep, sleeping too much, or waking up during the night
- ☐ Feeling of worthlessness or guilt
- ☐ Thoughts of death
- ☐ Too much energy
- ☐ Have gone days without sleeping
- ☐ None

48. What are your child's religious affiliation/spiritual beliefs?

_____

_____

49. Tell us about how your child's identities have shaped their lived experience.

_____

_____

50. To the best of your knowledge, has your child ever used drugs, alcohol, tobacco, or caffeine?
☐ Yes ☐ No If yes, which substances have they used? *Check all that apply.*

☐ Caffeine
☐ Nicotine (including vaping)
☐ Opioids, stimulants or benzodiazepines
☐ Other
If Other, please describe _____

☐ Misused prescription medications, over-the-counter medications, or household products
☐ Illicit or street drugs (marijuana, cocaine, crystal meth, heroin, etc.)

Please list the name of the person completing this form and the relationship to the patient

_____ _____
Name Relationship

42. In the last 3 months, has your child experienced any of the following related to anxiety concerns?
Check all that apply

- ☐ Worry about a number of things
- ☐ Anxiety or fear of social situations
- ☐ Panic attacks
- ☐ Feeling restless
- ☐ Rituals to lower anxiety
- ☐ Intrusive memories/flashbacks
- ☐ Avoid people/places that bring up memories
- ☐ Other

  If Other, please describe _____

- ☐ Feel anxious a majority of the time/difficult to control the worry
- ☐ Fear others are judging you or worry you will embarrass yourself
- ☐ Racing thoughts
- ☐ Obsessive thinking
- ☐ Nightmares
- ☐ None

43. Has your child ever contemplated suicide? ☐ Yes ☐ No ☐ Unsure ☐ Unknown
If yes, when was the last time they thought about suicide?
☐ Within the last week ☐ Within the last month ☐ Within the last year ☐ More than a year ago

44. Has your child ever engaged in any kind of self-harm? ☐ Yes ☐ No ☐ Unsure ☐ Unknown
If yes, when was the last time they thought about self-harm?
☐ Within the last week ☐ Within the last month ☐ Within the last year ☐ More than a year ago

45. Has your child ever received any of the following services outside of the HealthPartners network?
Check all that apply.

- ☐ Individual therapy
- ☐ Eating disorder treatment
- ☐ Psychological or neuropsychological testing
- ☐ Intensive in-home services: ARMHS, CTSS family worker, or ILS (Independent Living Skills)
- ☐ Partial hospitalization program, day treatment, intensive outpatient program or DBT
- ☐ Inpatient hospitalization
- ☐ Eating disorder treatment
- ☐ Transcranial magnetic stimulation (TMS)
- ☐ Psychological or neuropsychological testing
- ☐ Occupational therapist
- ☐ Neurologist
- ☐ Substance use treatment
- ☐ Other

  If Other, please describe _____

- ☐ Family or couples therapy
- ☐ Psychiatry or medication management
- ☐ Case management or case manager
- ☐ Phone, text, or online crisis services
- ☐ Residential treatment or IRTS
- ☐ Emergency room or crisis assessments Services
- ☐ Current or past commitment
- ☐ Electroconvulsive Therapy (ECT)
- ☐ Speech therapist
- ☐ Cardiologist
- ☐ Geneticist/genetic testing
- ☐ None

46. What are your child's weak areas?
Examples include self-critical, perfectionistic, shy, procrastination, unable to take redirection, etc.

_____

_____

47. What strengths does your child have?
Examples include commitment, intelligence, gratitude, forgiveness, humor, etc.

_____

_____

Outside Providers Contact Information

The Melrose Treatment team would like to communicate and best coordinate care with any outside providers you may be working with currently. Please list the names and contact information below of any outside providers you or your loved one have currently established care.

Do you attend the University of Minnesota?

☐ Yes ☐ No

Primary Medical Doctor

Name	
Clinic name	Phone number

Therapist

Name	
Clinic name	Phone number

Psychiatrist

Name	
Clinic name	Phone number

Other (for example: social worker, other medical provider, school counselor, legal, etc.)

Name	
Role	Phone number

Other (for example: social worker, other medical provider, school counselor, legal, etc.)

Name	
Role	Phone number

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