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

Child Initial Assessment

The following information will assist our clinical staff with getting to know your child and completing the initial assessment appointment. **It is very important to fill this out as completely as possible prior to your initial appointment**. Providers may ask you to fill this out prior to being seen. Please use black ink.

Child's legal name	Preferred name	Child's date of birth	Child's age

Form completed by	Date form completed

What sex was your child assigned at birth? ☐ Male ☐ Female	Gender identity

What pronouns should we use to refer to your child?
☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____

What prompted you to schedule an Eating Disorder Assessment for your child at Melrose Center? _____

Please list the name of who referred you to Melrose Center? What is their relationship to you?

I have heard about Melrose Center from (check all that apply):

☐ Friend/Family/Neighbor ☐ Medical or Mental Health Provider ☐ Online (Facebook, website, search)
☐ Advertisement (Radio, print, billboard) ☐ School Social Worker or Counselor ☐ Other _____

LIVING SITUATION

Parent

Name		
Street address	☐ Rent ☐ Own	
City, State, ZIP		
Home phone	Work phone	
Education	Occupation	

Parent

Name		
Street address	☐ Rent ☐ Own	
City, State, ZIP		
Home phone	Work phone	
Education	Occupation	

Family status:

☐ Married ☐ Separated (in_____ / _____) ☐ Divorced (in_____ / _____) ☐ Never married

If separated, child's primary residence is with whom? _____

If parents are divorced or separated, how often does the child visit with the other parent? _____

Name of child's legal guardian _____

Name of child's foster parents _____

Foster parents' address _____

Stepparent

Name	
Street address	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Stepparent

Name	
Street address	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Current living arrangements

- ☐ Lives with both parents (biological or adoptive) in same household
- ☐ Single parent
- ☐ Shared custody (parents in different households) primary residence _____
- ☐ Relative/guardian's home
- ☐ Other, describe _____
- ☐ Hospital
- ☐ Residential care
- ☐ Temporary housing
- ☐ Friend's home
- ☐ Hospital
- ☐ Homeless

Is your child adopted? ☐ No ☐ Yes. If yes, how old was your child at the time of adoption? _____

Is your child aware of the adoption? ☐ No ☐ Yes

FAMILY ENVIRONMENT/RELATIONSHIPS

Are any other issues seriously affecting your family of which you would like us to be aware?

Has your child ever experienced or witnessed any of the following?

- ☐ Domestic violence/abuse
- ☐ Community violence
- ☐ Sexual assault/molestation
- ☐ Emotional abuse
- ☐ Physical neglect
- ☐ Natural disasters
- ☐ Physical abuse
- ☐ Fire
- ☐ Other

☐ Yes ☐ No Have you or your child been involved with any of the following county resources?

- ☐ PCA (Personal Care Assistance)
- ☐ Foster care
- ☐ County social worker
- ☐ Respite care
- ☐ PACER (Parent Advocacy Coalition for Educational Rights)
- ☐ The ARC
- ☐ Developmental disorder social worker
- ☐ Other _____

☐ Yes ☐ No Does your child have a history of legal charges? Please describe.

_____

☐ Yes ☐ No Is your child currently on probation?

☐ Yes ☐ No Has your child ever been on probation?

☐ Yes ☐ No Has your child ever been court-ordered into chemical health or mental health treatment?

☐ Yes ☐ No Has your child ever had involvement with Child Protection Services (CPS)? Please describe.

_____

Name of CPS caseworker(s) assigned to family (if applicable)

☐ None reported _____

Name of guardian ad litem (GAL) or court appointed special advocate (CASA) assigned to family?

☐ None reported _____

NUTRITION AND FEEDING

Current weight _____ Height _____ Date _____

☐ Yes ☐ No Does the child have difficulty gaining weight?

☐ Yes ☐ No Have there been past or present nutritional concerns?

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

What foods does your child avoid? _____

What help have you had in managing nutrition? (e.g., dietitian from Pediatric Home Services, nutritional consultations, primary doctor's suggestions, special formula, foods, etc.) _____

List any family (immediate/extended) medical history of feeding/eating disorders, GI disorders, food peculiarities. Include ages especially for siblings. _____

Are you having any problems managing the child's behavior related to feeding? (e.g., refusal to eat, vomiting, eating very slowly, tantrums)

What eating–related symptoms or behaviors does your child experience?

	Current & Frequency	Past & Frequency
Overeating/Emotional Eating/Binge eating		
Purging (self-induced vomiting)		
Restricting food / under-eating		
Compulsive or excessive exercise		
Diet pills / supplements or weight loss programs		
Hiding food		
Excessively Picky eater		
Laxative use		
Fears of food		

When did you first notice your child had a problem with eating and what was going on in their life then?

Eating Pattern (over past 1 month)

Breakfast _____

Snack (a.m.) _____

Lunch _____

Snack (p.m.) _____

Dinner _____

Snack (evening) _____

Fluid intake _____

What rules does your child follow around eating? _____

BIRTH HISTORY

Term (# of weeks) _____ Premature (# of weeks) _____

Prenatal care? _____

Birth weight _____ Length _____

List any significant birth history (e.g., difficult delivery, use of oxygen, extended length of stay in the hospital/NICU, use of ventilator, etc.) _____

EDUCATION

☐ Yes ☐ No Does the child currently attend school or receive other school services?

If yes, Where? _____ Grade _____

Special education services _____

☐ Yes ☐ No Is your child involved in any sports or after-school activities? If yes, please explain:

MEDICAL HISTORY

Please list all of your child's medications, or bring a list with you of all prescribed, over the counter drugs, vitamins and/or herbal supplements that he/she currently takes:

☐ Yes ☐ No Does your child have any history of medical problems? If yes, please explain:

☐ Yes ☐ No Does your child have any history of surgeries? If yes, please explain:

☐ Yes ☐ No Has your child ever been hospitalized? If yes, please explain:

☐ Yes ☐ No Does your child have any known drug, environmental, or food allergies? If yes, please explain:

MEDICAL HISTORY continued

Date of last bowel movement? _____

Has your child experienced any of the following in the past 3 months? Check all that apply.

Medical

- ☐ Lightheadedness
- ☐ Dizziness/fainting
- ☐ Chest pain
- ☐ Sensitivity to cold
- ☐ Leg cramps
- ☐ Shortness of breath
- ☐ Irregular pulse
- ☐ Heart racing
- ☐ Neck/back pain
- ☐ Excessive sweating
- ☐ Blueness of lips/fingers
- ☐ Chronic pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bowel problems
- ☐ Stomach problems
- ☐ Trouble swallowing
- ☐ Appetite change
- ☐ Heartburn
- ☐ Cough
- ☐ Vomiting blood
- ☐ Dry mouth
- ☐ Visual disturbances

Mood

- ☐ Depressed mood/unhappy
- ☐ Little interest or pleasure in most activities
- ☐ Appetite or weight changes
- ☐ Trouble falling asleep
- ☐ Waking up in the middle of the night
- ☐ Sleeping too much
- ☐ Fatigue
- ☐ Feelings of worthlessness/guilt
- ☐ Problems concentrating
- ☐ Problems making decisions
- ☐ Thoughts of death
- ☐ Too much energy
- ☐ Impulsive behaviors
- ☐ Have gone days without sleeping

Anxiety

- ☐ Worry about a number of things
- ☐ Feel anxious majority of the time
- ☐ Difficult to control the worry
- ☐ Anxiety or fear in social situations
- ☐ Fear others are judging them
- ☐ Worry they will embarrass themselves
- ☐ Panic attacks
- ☐ Racing thoughts
- ☐ Feeling restless
- ☐ Obsessive thinking
- ☐ Rituals to lower anxiety
- ☐ Nightmares
- ☐ Intrusive memories/ flashbacks
- ☐ Avoid people or places that bring up memories

☐ Yes ☐ No Has your child ever contemplated suicide in the past or ever engaged in any kind of self-harm behavior (suicide attempt or self-harm)? If yes, please explain:

_____

_____

☐ Yes ☐ No Has your child ever talked with a psychologist, therapist, counselor, chaplain or other professional about emotional or personal concerns? If yes, please complete the following:

Reason for treatment	Setting (inpatient/outpatient)	Dates	Who did they talk to?

☐ Yes ☐ No Do you have any other concerns about the child's behavior at home or school? If yes, please explain:

_____

_____

Place an “X” in appropriate boxes to identify all illnesses/conditions in your child’s blood relatives:

Illness/Condition	Family Member							
	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other
Depression								
Chronic/General anxiety								
Bipolar/manic depression								
Schizophrenia/psychosis								
Eating disorder								
Psychiatric hospitalization								
Alcohol/drug abuse								
Suicide/suicide attempt								
Phobias/Fears								

What are your child’s weak areas? _____

What are your child’s strengths? _____

Does your child have friends? _____

What does your child do for fun? _____

Please describe any religious affiliation or spiritual beliefs and their impact, if any, on your child’s service preferences:

Please indicate your child’s ethnicity or cultural identification: _____

Is there anything else you feel it is important for us to know right now? _____

What do you want to achieve with eating disorder treatment for your child and family? _____

Signature of person filling out the form	Printed name	Date

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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