

Expectation of Treatment: (Check all that apply)

- Stabilization
- Safety
- Medication Evaluation
- Other _____

Expectation for Involvement in Care: (Check all that apply)

- I am willing to participate in:
- Family Therapy
 - Family Phone Calls
 - Family Visits
 - Other _____

Assessment of Child's Strengths: (Check all that apply)

- | | | | |
|--------------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> Intelligent | <input type="checkbox"/> Insightful | <input type="checkbox"/> Good Problem Solver | <input type="checkbox"/> Kind / Compassionate |
| <input type="checkbox"/> Helpful | <input type="checkbox"/> Leader | <input type="checkbox"/> Responsible | <input type="checkbox"/> Good Social Skills |
| <input type="checkbox"/> Resilient | <input type="checkbox"/> Humorous | <input type="checkbox"/> Goal Directed | <input type="checkbox"/> Good Communication Skills |
| <input type="checkbox"/> Creative | <input type="checkbox"/> Flexible | <input type="checkbox"/> Good Health | <input type="checkbox"/> Other _____ |

Assessment of Barriers to Treatment: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor Communication Skills | <input type="checkbox"/> Poor Social Skills | <input type="checkbox"/> Anger Issues |
| <input type="checkbox"/> Poor Self Esteem | <input type="checkbox"/> Pessimistic | <input type="checkbox"/> Rigidity |
| <input type="checkbox"/> Poor Attention Span | <input type="checkbox"/> Poor Health | <input type="checkbox"/> Personal Attitude |
| <input type="checkbox"/> Drug / Alcohol Addiction | <input type="checkbox"/> No Accountability | <input type="checkbox"/> Other _____ |

Long Term Goals for Treatment: (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Improve Social Skills | <input type="checkbox"/> Improve Anger Management |
| <input type="checkbox"/> Improve Family Relations | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Decrease Symptomology | <input type="checkbox"/> Other _____ |

(Please Initial) **I have been given the opportunity to express my expectations and did receive education and a copy of the Family Information Packet that includes information regarding patient/resident rights, grievance procedure, correspondence, visitation, behavioral management, emergency procedures, abuse and neglect, and religious/cultural policy.**

You have a right to receive a copy(ies) of the authorization to obtain/disclose protected health information. If you wish to have a copy of the releases of information please indicate so by checking below.

- Yes, I have accepted a copy of the authorization to obtain or disclose protected health care information.
- No, I have declined a copy of the authorization to obtain or disclose protected health care information.

Parent / Guardian Signature: _____ **Date:** _____



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KOOTENAI BEHAVIORAL HEALTH CENTER
Coeur d'Alene, Idaho

FAMILY EXPECTATION EVALUATION