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)
- Intelligent
- Insightful
- Good Problem Solver
- Kind / Compassionate
- Helpful
- Leader
- Responsible
- Good Social Skills
- Resilient
- Humorous
- Goal Directed
- Good Communication Skills
- Creative
- Flexible
- Good Health
- Other

Assessment of Barriers to Treatment: (Check all that apply)
- Poor Communication Skills
- Poor Social Skills
- Anger Issues
- Poor Self Esteem
- Pessimistic
- Rigidity
- Poor Attention Span
- Poor Health
- Personal Attitude
- Drug / Alcohol Addiction
- No Accountability
- Other

Long Term Goals for Treatment: (Check all that apply)
- Improve Social Skills
- Improve Anger Management
- Improve Family Relations
- Medication Management
- 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: ____________