Family Expectations Evaluation

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
❏ Decrease Symptomology	❏ 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 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:** ______________

Patient Identification – Write in or attach patient label

Name:

MRN #:

CSN #:

Age/Sex:

- Consent Treatment
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