CROSSROADS BEHAVIORAL HEALTH, INC.

91-1010 Shangrila Street, Suite 105, Kapolei, HI 96707
Phone: 808.377.4300 Fax: 808.484.1129

Competent Compassionate Care

Aloha,

Thank you for choosing Crossroads Behavior Health, Inc.

In order to provide you with the most efficient and effective care, our initial patient packet is now available online so that you may complete the forms at your leisure prior to your appointment. These forms include:

1). **Demographic Form**
This form allows us to obtain important contact and insurance information.

2). **Outpatient Service Contract**
This form describes our therapy, our services, confidentiality and billing as well as gives consent to treatment.

3). **HIPAA**
This form describes patient privacy.

4). **Adult Intake Questionnaire**
This form helps us to obtain an accurate history.

Please bring the forms listed above, as well as your ID and insurance card to your first appointment. Copays are due at the time of service and are payable in the form of cash or check (made out to CBH).

Please do not hesitate to contact us if you have any questions or concerns. We will be happy to assist you.

Mahalo,

Crossroads Behavioral Health, Inc.

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PATIENT INFORMATION

First Name: _____ MI ____ Last Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Date of Birth: _____

CONTACT INFORMATION

Cell Phone: _____ Home Phone: _____

Business Phone: _____ Preferred Contact: Text Email Phone

RACE / ETHNICTY

Primary Race/Ethnicity: ***(please check one)***

__White
__Black or African American
__American Indian or Alaska Native
__Asian
__Native Hawaiian or Other Pacific Islander
__Hispanic

Secondary Race/Ethnicity: ***(please check one)***

__White
__Black or African American
__American Indian or Alaska Native
__Asian
__Native Hawaiian or Other Pacific Islander
__Hispanic

RELATIONSHIP INFORMATION

Marital Status: ***(please check one)***

__Married __Single __Widowed __Divorced __Legally Separated __Domestic Partner

EMPLOYMENT / STUDENT INFORMATION

Employment Status: ***(please check one)***

__Employed __Disabled __Retired __Part-time __Full-time __Student __Not Employed

Employer:_____ **Employer Phone:** _____

Student Status: ***(please check one)***

__Full-time __Part-time __Not a student **School:** _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone: _____

Relationship: ***(please check one)***

__Spouse __Child __Other __Mother __Father
__ Sibling __Grandparent __Aunt/Uncle __Grandchild __Domestic Partner

REFERRAL INFORMATION

Referring Physician: _____ **Physician Phone:** _____

PERSON RESPONSIBLE FOR BILL

Primary Insurance: _____ **Policy#:** _____

Relationship to patient: ***(please check one)***

__Self __ Spouse __Child __ Mother __ Father __Grandparent __Other

First Name: _____ MI ____ Last Name:_____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of Birth: _____ Gender: M F

Secondary Insurance: _____ **Policy#:** _____

Relationship to patient: ***(please check one)***

__Self __ Spouse __Child __ Mother __ Father __Grandparent __Other

First Name: _____ MI ____ Last Name:_____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of Birth: _____ Gender: M F

Statements: (*please check one*)

__ I give Crossroads Behavioral Health permission to mail account statements to my home address listed above

___ Please hold my statement – do not mail.

INSURANCE AUTHORIZATION

_____ I authorize the release of any medical or other information necessary to process a claim(s). I also request payment of government benefits either to myself or the party who accepts assignment. I am the patient or authorized representative.

_____I authorize payment of medical benefits to the servicing physician or provider of services. I am the patient or authorized representative.

_____ _____

Signature Date

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Outpatient Services Contract

Welcome to Crossroads Behavioral Health, Inc. (CBH, Inc.). This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the patient, and the particular problems you bring forward. Many different methods may be used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home**.**

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

The first few sessions of therapy will involve an evaluation of your needs. By the end of the evaluation, your provider will be able to offer you some initial impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your provider. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about any procedures, it is important to discuss them whenever they arise. This discussion often leads to better treatment outcomes. However, if your doubts persist and you do not feel we are able to work together, a list can be provided to you of other qualified professionals whose services you might prefer.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and your provider can only release information about our work to others with your written permission. But there are a few exceptions.

A. Legal Proceedings: In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

B. Abuse: There are some situations in which your provider is legally obligated to take action to protect others from harm, even if they have to reveal some information about a patient's treatment. For example, if your provider believes that a child, elderly, or disabled person is being abused, s/he must file a report with the appropriate state agency.

C. **Danger To Others:** If your provider believes that a patient is threatening serious bodily harm to another, they are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

D. **Danger To Oneself:** If the patient threatens to harm himself/herself, your provider may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations occur quite rarely. But, if this situation occurs, your provider will make every effort to fully discuss it with you before taking any action.

Occasionally your provider may find it helpful to consult other professionals. During a consultation, every effort is made to avoid revealing anyone's identity. The consultant is also legally bound to keep the information confidential. If you don't object, your provider will not tell you about these consultations unless s/he feels that it is important to your work together.

Minors: If you are a minor, under the age of 18, please be aware that the law may provide your parents the right to information about your treatment. For teenagers, it is the policy at CBH, Inc. to request an agreement from your parents that they be provided with only general information about our work together, unless there is a high risk that you will seriously harm yourself or someone else. Before giving them any information, your provider will discuss the matter with you, if possible, and do their best to address any objections you may have.

Electronic Communication: It is very important to be aware that e-mail, text and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. For example, e-mails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Texts can be read by others with or without authorized accessed to your phone. Faxes can easily be sent erroneously to the wrong address. In addition, communicating with your provider via electronic communication may compromise your confidentiality as these exchanges may become part of your medical record. Please notify your provider if you decide to avoid or limit in any way the use of any or all of the above mentioned communication devices. Please do not use e-mail, faxes or texts for emergencies.

Dual Relationships: Not all dual relationships are unethical or avoidable. However, many types of dual relationships can either become exploitive of the patient, or create conditions that might impair your provider's objectivity, clinical judgment, or therapeutic effectiveness. Your provider will assess carefully before entering into any dual relationships with patients, and discuss with you the potential benefits and difficulties that may be involved in continuing therapy. Your provider will also discontinue any relationship if s/he finds it is interfering with the effectiveness of the therapeutic process. It should also be noted that in order to maintain your confidentiality, your provider may not acknowledge your presence if s/he sees you in the community. This is not done to be rude or unkind, but to protect your confidentiality.

Waiting Room: Your confidentiality is of the utmost important to us. In order to maintain the highest level of confidentiality and comfort for our patients, we ask that only family members of patients be permitted in the waiting room. We humbly ask that friends or coworkers who come with you to therapy, kindly wait in the lobby at the front of the building or walk around the grounds until the session is over. This will help to prevent our waiting room from overcrowding.

Video Surveillance: For your safety and the safety of others our offices are monitored by video surveillance. **(Please initial here):** _____

PROFESSIONAL RECORDS

CBH, Inc. providers are required to keep records of their professional services, your treatment, or your work together. Because these records contain information that can be easily misunderstood by someone who is not a mental health professional, our general policy is that patients may not review them; however, we will provide at your request a treatment summary unless it is believed that doing so would be emotionally damaging. If that is the case, we will be happy to send the summary to another mental health professional who is working with you.

SESSIONS AND FEES

Meetings: The initial evaluation may last from 2 to 4 sessions. During this time, you and your provider will be able to determine if s/he can meet your treatment needs. If you decide to initiate treatment, your provider will schedule one 45-55 minute session per week unless other arrangements are made.

Professional Fees: Our hourly fee is $220 plus applicable Hawaii State General Excise Tax of 4.712%. In addition to weekly appointments, CBH, Inc. charges $220 per hour for other professional services you may require, billed per quarter hour of work performed. These fees are not likely covered by your Health Insurance so your provider will discuss this with you prior to conducting any such service. **(Please initial here):** _____

CANCELLATIONS

Once an appointment hour is scheduled, you will be expected to pay for it in full **($168)** unless you provide **72 hours advance notice of cancellation**, and/or we both agree that you were unable to attend due to circumstances beyond your control. Providers of CBH, Inc. may terminate therapy after 2 missed appointments for non-emergent purposes**. (Please** _____

Promptness for Scheduled Appointments: Out of respect, your provider will make every effort to begin your session on time. However, due to the nature of medical care, some situations may arise that might cause minor delays. In these instances, your provider will make every effort to extend your session so that you are afforded your allotted time. **(Please Initial Here):** _____

In order to maintain ethical billing standards, your provider will not bill your Health Insurance Company on your behalf for sessions that start late due to your tardiness in excess of 15 minutes. In these instances, you will be responsible for payment of that session at the rates mentioned above.

DISPUTES

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you nor your attorney(s) nor anyone else acting on your behalf will call on CBH, Inc. providers to testify in court or at any other proceeding, nor will a disclosure of psychotherapy records be requested**. (Please initial here):** _____

Mediation and Arbitration: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall be referred to mediation, before, and as a pre-condition of the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of CBH, Inc., your provider and the patient(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in accordance with the rules of the American Arbitration Association which is in effect at the time the demand for arbitration is filed. In the event that your account is overdue and there is no agreement on a payment plan, CBH, Inc. and your provider can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as for attorney's fees. In the case of arbitration, the arbitrator will determine that sum. **(Please Initial here):** _____

INSURANCE

Billing and Payments: Billing and Payments: You will be expected to pay for each session at the time it is held, unless it is agreed otherwise or unless you have insurance coverage. Often times this takes the form of a copay and tax if applicable. Payment schedules for other professional services will be agreed to when they are requested.

Insurance Reimbursement: In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. CBH, Inc. and your provider will submit claims on your behalf; however, ***you (not your insurance company) are ultimately responsible for full payment of all fees.*** It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course CBH, Inc. and your provider will assist you with whatever information, based on our experience, and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, CBH, Inc. and your provider will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that most insurance companies require you to authorize CBH Providers to provide them with a clinical diagnosis. Sometimes additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases) may also be necessary. Whatever the case may be, this information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, CBH, Inc. and your provider does not have control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

CONTACTING YOUR PROVIDER

The providers at CBH, Inc. are often unavailable by phone. They will not answer the phone when working with patients. When your provider is unavailable you will have the opportunity to leave a message on voicemail that will be monitored frequently. Your provider will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform your provider of some times when you will be available. **(Please Initial Here):** _____

Emergencies: If you are unable to reach your provider and feel that you cannot wait for them to return your call, contact the ACCESS Line (808) 832-3100, your family physician, 911 or go to the nearest emergency room and ask for the psychologist or psychiatrist on call. If your provider will be unavailable for an extended time, they will provide you with the name of a colleague to contact, if necessary. **(Please Initial Here):** _____

Acknowledgment of Receipt of Outpatient Services Contract
And Notice of Privacy Practices for Crossroads Behavioral Health, Inc.

I have received a copy of the Outpatient Services Contract and my privacy rights according to HIPAA. I have been given the opportunity to ask questions about these documents. In signing this document I am acknowledging that I understand these documents and agree to the terms.

_____

Signature of Patient if over the age of 18, or Authorized Representative Date

_____

Signature of child if over the age of 14 Date

_____

Printed Name and Relationship of Authorized Representative (Parent or Guardian of Child under 18)

2/10, APA Rev 12/99

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ADULT HISTORY

Patient Name: _____ Today's Date: _____

Form Completed by: _____ Relationship: _____

Date of Birth: _____ Ethnicity: _____

Referred by: _____ Reason for Referral: _____

Emergency Contact: _____ Emergency Phone: _____

PRESENTING PROBLEM

How long ago did the problem begin: _____

Reason(s) for seeking services:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Doctor's Note:

SYMPTOM CHECKLIST

MDD (5+)
- ☐ Increase/decrease in sleep
- ☐ Decreased interest/pleasure
- ☐ Guilt/worthlessness
- ☐ Decreased energy
- ☐ Difficulties with concentration
- ☐ Appetite increase/ decrease
- ☐ Restless/slowed down
- ☐ Thoughts of harming self/others

DYS (2+)
- ☐ Appetite increase/decrease
- ☐ Increase/decrease in sleep
- ☐ Decreased energy
- ☐ Low self-esteem
- ☐ Difficulties with concentration
- ☐ Hopelessness

ME (3+)
- ☐ Inflated self-esteem
- ☐ More talkative than usual
- ☐ Decreased need for sleep
- ☐ Distractibility
- ☐ Racing thoughts
- ☐ Increased goal directed activity
- ☐ Involvement in risky or pleasurable activity

GAD (3+)
- ☐ Unable to relax
- ☐ Easily fatigued
- ☐ Difficulty concentrating
- ☐ Mind goes blank
- ☐ Irritability
- ☐ Muscle tension
- ☐ Sleep difficulties

SUB
- ☐ Use of alcohol/drugs
- ☐ Past use of alcohol/drugs
- ☐ Failure to fulfill obligations due to substances
- ☐ Substance related legal issues
- ☐ Use of substances when Hazardous
- ☐ Continued use of substances despite cause of difficulties
- ☐ Tolerance to/withdrawal from substance

PA (4+)
- ☐ Heart pounding
- ☐ Sweating
- ☐ Trembling
- ☐ Shortness of breath
- ☐ Feeling of choking
- ☐ Chest pain
- ☐ Nausea
- ☐ Dizzy/lightheaded
- ☐ Feeling of unreality
- ☐ Feeling detached from self
- ☐ Fear of losing control
- ☐ Fear of dying
- ☐ Numbness/tingling
- ☐ Chills/hot flushes

(1+)
- ☐ Fear of future anxiety attacks
- ☐ Worry about anxiety attacks
- ☐ Change in behavior related to anxiety attacks

A
- ☐ Refusal to maintain body wt
- ☐ Restless/on edge
- ☐ Fear of gaining weight or becoming fat even if under weight
- ☐ Disturbance in way body wt or shape is experienced
- ☐ Absence of 3 consecutive menstrual cycles

B
- ☐ Recurrent binge eating
- ☐ Eating large amounts of food w/in a discrete time
- ☐ Lack of control over binging
- ☐ Behaviors to compensate for possible wt gain (ie: vomit, (exercise, laxatives, etc.)
- ☐ Binging & compensation behaviors occur 2x wk-3mo
- ☐ Self-evaluation influenced by body shape/wt

PTS (1)
- ☐ Experience/witness trauma
- ☐ Trauma response involved fear, helplessness, or horror

Re-experience trauma (1+)
- ☐ Thoughts/images
- ☐ Nightmares
- ☐ Act or feeling trauma recurring
- ☐ Distress to cues resembling trauma

*** *Avoidance of trauma (3+)***
- ☐ Avoid thoughts, feelings, or talk about trauma
- ☐ Avoid activities, places, people reminiscent of trauma
- ☐ Cannot recall parts of trauma
- ☐ Decreased interest in activities
- ☐ Feel detached from others
- ☐ Feel future is limited

Arousal (2+)
- ☐ Difficulty falling or staying asleep
- ☐ Irritability/outbursts of anger
- ☐ Hypervigilence
- ☐ Exaggerated startle response

FUNCT
- ☐ Family difficulties
- ☐ Marital difficulties
- ☐ Social difficulties
- ☐ Educational difficulties
- ☐ Job difficulties
- ☐ Housing difficulties
- ☐ Financial difficulties
- ☐ Legal difficulties

OTHER:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

MEDICAL HISTORY

	Yes	No	Hospitalizations/Surgeries	Date
Serious accidents	☐	☐	_____	_____
Allergies	☐	☐	_____	_____
Frequent headaches	☐	☐	_____	_____
Asthma	☐	☐	_____	_____
Diabetes	☐	☐	_____	_____
Thyroid difficulties	☐	☐		
Head injuries	☐	☐	**Medications**	**Dose/Frequency**
Nutrition concerns	☐	☐	_____	_____
Problems with pain	☐	☐	_____	_____
Hearing problems	☐	☐	_____	_____
Vision problems	☐	☐	_____	_____

Current Medical Problems

_____

_____

_____

Primary Care Provider: _____ Last Physical Exam _____

Doctor's Note:

MENTAL HEALTH

	Yes	No	
Past psychiatric evaluation	☐	☐	Date(s): _____
Prior diagnosis of a mental health disorder	☐	☐	Diagnoses: _____
Prior use of psychiatric medication	☐	☐	Name(s): _____
History of harm to self/others	☐	☐	Who/When: _____
History of suicide in your family	☐	☐	Who/When: _____
Past psychiatric hospitalization	☐	☐	Date(s): _____

Doctor's Note:

HISTORY OF ABUSE

	Yes	No	
Emotional Abuse	☐	☐	Who/When: _____
Verbal Abuse	☐	☐	Who/When: _____
Physical Abuse	☐	☐	Who/When: _____
Sexual Abuse	☐	☐	Who/When: _____

Doctor's Note:

SCHOOL HISTORY

	Yes	No	
Academic Difficulties	☐	☐	Grade/Age: _____
Behavioral Difficulties	☐	☐	Grade/Age: _____
Special Education	☐	☐	Grade/Age: _____
Gifted Classes	☐	☐	Grade/Age: _____
Graduated High School	☐	☐	Name/Yr: _____
Attended College	☐	☐	Name/Yr: _____

Doctor's Note:

IMMEDIATE FAMILY HISTORY

	Yes	No	
Medical Illness	☐	☐	Diagnoses: _____
Mental Health Illness	☐	☐	Diagnoses: _____
Substance Abuse	☐	☐	Type(s): _____
Legal Issues (arrests/jail)	☐	☐	Type(s): _____
Learning Difficulties/Disabilities	☐	☐	Diagnoses: _____

Doctor's Note:

FAMILY INFORMATION

				Relationship		
		Living	**Deceased**	**Good**	**Avg**	**Poor**
Mother's Name: _____	Age: _____	☐	☐	☐	☐	☐
Educational Level: _____						
Occupation: _____						
Father's Name: _____	Age: _____	☐	☐	☐	☐	☐
Educational Level: _____						
Occupation: _____						
Stepmother's Name: _____	Age: _____	☐	☐	☐	☐	☐
Educational Level: _____						
Occupation: _____						
Stepfather's Name: _____	Age: _____	☐	☐	☐	☐	☐
Educational Level: _____						
Occupation: _____						
Brother's Name/Age: _____	Age: _____	☐	☐	☐	☐	☐
Brother's Name/Age: _____	Age: _____	☐	☐	☐	☐	☐
Brother's Name/Age: _____	Age: _____	☐	☐	☐	☐	☐
Sister's Name/Age: _____	Age: _____	☐	☐	☐	☐	☐
Sister's Name/Age: _____	Age: _____	☐	☐	☐	☐	☐
Sister's Name/Age: _____	Age: _____	☐	☐	☐	☐	☐
Spouse's Name: _____	Age: _____	☐	☐	☐	☐	☐
Educational Level: _____						
Occupation: _____						
Child's Name: _____	Age: _____	Gender: _____		☐	☐	☐
Child's Name: _____	Age: _____	Gender: _____		☐	☐	☐
Child's Name: _____	Age: _____	Gender: _____		☐	☐	☐
Child's Name: _____	Age: _____	Gender: _____		☐	☐	☐
Child's Name: _____	Age: _____	Gender: _____		☐	☐	☐

Doctor's Note:

FAMILY INFORMATION

Doctor's Note:

JOB HISTORY

Place of Employment	Position	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Doctor's Note:

LEGAL HISTORY

	Yes	No	
Past trouble w/the law	☐	☐	When/Why: _____
Gone to court	☐	☐	When/Why: _____
Been arrested	☐	☐	When/Why: _____

Doctor's Note:

SUBSTANCE USE HISTORY

	Yes	No	
Past use of drugs or alcohol	☐	☐	What/When: _____
Use of drugs or alcohol within past mo.	☐	☐	What/When: _____
Past treatment for drugs/alcohol	☐	☐	What/When: _____
Addicted to eating	☐	☐	When: _____
Addicted to gambling	☐	☐	When: _____
Addicted to spending money	☐	☐	When: _____
Addicted to sex	☐	☐	When: _____

Doctor's Note:

SOCIAL RELATIONSHIPS

	Yes	No	
People are supportive of you	☐	☐	Who: _____
You have people you can tell personal information	☐	☐	Who: _____
You have people to do things with	☐	☐	Who: _____

Doctor's Note:

EMOTIONAL AND BEHAVIORAL FUNCTIONING

Strengths

_____

_____

_____

Limitations/Weaknesses

_____

_____

_____

Hobbies

_____

_____

_____

_____

_____

_____

Doctor's Note:

GOALS FOR THERAPY

1. _____
2. _____
3. _____
4. _____
5. _____

Doctor's Note: