999 164th Avenue NE
Bellevue, Washington 98008
425-747-4937 TDD
FAX 425-957-0351

11829 97th Avenue NE
Kirkland, Washington 98034
425-827-4937
FAX 425-827-7047

15600 Redmond Way, Ste. 102
Redmond, Washington 98052
425-869-6036
FAX: 425-869-6037

Information provided will be kept strictly CONFIDENTIAL!

CLIENT REGISTRATION

First Name						
Last Name						
Parent / Guardian Name						
Street Address						
City		Zip				
Preferred Phone		Message?	☐ Yes	☐ No	Contact Name	
Alternate Phone		Message?	☐ Yes	☐ No	Contact Name	
Email						
Birthdate		Age				
School		Grade				
Gender	☐ Female		☐ Male			
	☐ Transgender (F to M)		☐ Transgender (M to F)			
	☐ Other		☐ Prefer not to disclose			
Ethnicity	☐ American Indian or Alaska Native		☐ Asian or Asian American			
	☐ Black or African American		☐ Hawaiian native or pacific islander			
	☐ Hispanic or Latino		☐ Middle Eastern / Arab			
	☐ White / Caucasian		☐ Multi-Racial			
	☐ Other ___________________		☐ Prefer not to disclose			
Religion						
Employment	☐ Not Employed ☐ Part-Time ☐ Full-Time ☐ Seasonal ☐ Seeking Work					
Military Status	☐ None ☐ Active Military ☐ Veteran ☐ Seasonal ☐ Seeking Work					
Are you homeless?	☐ Yes	☐ No	Are you in foster care?	☐ Yes	☐ No	
Who do you live with?			Is there a Parenting Plan?	☐ Yes	☐ No	
Head Household	☐ Married/Partnered ☐ Single Female ☐ Single Male ☐ Blended ☐ Other					
Primary language(s) spoken?						
Do you have a disability?	☐ Yes	☐ No	If yes, please describe			
Accommodations or Interpreter needed?	☐ Yes	☐ No	If yes, please describe			
Who referred you to YES?						

Client Name:

FINANCIAL SCREENING

Youth Eastside Services accepts private insurance, Medicaid and offers a sliding fee scale. Regardless of your financial circumstances, you can find the help you need at YES!

FINANCIALLY RESPONSIBLE PERSON(S)

First Name				
Last Name				
Relationship to Client				
Billing Address				
City		Zip		
Phone		Message?	☐ Yes	☐ No
Alternate Phone		Message?	☐ Yes	☐ No

PRIMARY INSURANCE (If client has secondary coverage please complete secondary insurance form)

Insurance Company Name	
Insured's Name	
Insured's Employer	
Clients Relation to Insured	
Insurance Phone Number	
Identification Number	

SLIDING FEE SCALE

Number of people who live in your household?	
Number of people under 18 who live in your household?	
Annual Income	

FINANCIAL ACKNOWLEDGMENTS & CONSENT

☐ - I understand that I am fully responsible for ALL services not covered by my insurance including.

☐ - I understand that estimated benefits are NOT a guarantee of payment.

☐ - I understand that YES will bill my insurance company at its established full fees (if applicable).

☐ - I understand that payment is due when services are rendered.

☐ - I understand I will be charged a $20.00 NO SHOW fee for appointments cancelled less than 24 hours before the appointment.

☐ - I agree to provide YES with a copy of my insurance card(s), photo identification and/or proof of income (if applicable)

☐ - I agree to promptly notify the YES Billing Office if my insurance and/or financial circumstances change.

☐ - I understand if my account becomes past due it may be referred to a collection agency, whereupon I agree to pay all cost incurred.

I authorize Youth Eastside Services (YES) to bill my insurance/Medicaid/Employee Assistance Program (EAP) for services rendered to me/my family. I authorize YES to coordinate benefits and payments with my insurance/Medicaid/EAP. I authorize YES to send any and all required information to my insurance/Medicaid/EAP. I understand this authorization shall remain valid until written notice is given by me revoking this authorization. **I certify that I have read, understand and agree to the content of this agreement.**

Client Signature	Date
Parent/Guardian Signature	Date

Client Name:

CURRENT CONCERNS (What brings you to YES today?)

CONCERNS & SYMPTOMS (Check all that apply)

☐ Adjustment challenges	☐ Aggression	☐ Anger	☐ Anxiety
☐ Appetite Disturbance	☐ Behavior	☐ Bullying	☐ Court / Legal
☐ Depression	☐ Eating Disorder	☐ Excessive Energy	☐ Family Conflict
☐ Fatigue / Low Energy	☐ Fearful / Worry	☐ Gambling	☐ Gender Identity
☐ Grief	☐ Guilt	☐ Hallucinations	☐ Hopelessness
☐ Impulsivity	☐ Irritability	☐ Isolation	☐ Loss of Interest
☐ Lying / Stealing	☐ Medication Management	☐ Obsessions / Compulsions	☐ Panic Attacks
☐ Paranoia	☐ Peer Relationships	☐ Phobias	☐ Racing Thoughts
☐ Risky Behavior	☐ Sadness	☐ School Problems	☐ Self Esteem Issues
☐ Self-Injury	☐ Sexual Orientation	☐ Sleep Changes	☐ Substance Use (client)
☐ Substance Use (family)	☐ Suicidal Thoughts / Actions	☐ Trauma	☐ Violence
Have you had any prior Behavioral Health services?		☐ Yes	☐ No

ALCOHOL/DRUG USE - Have you ever tried the following? (Check all that apply)

☐ Alcohol	☐ Tobacco/Nicotine/Vaping	☐ Marijuana	☐ Hallucinogens / LSD
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (Pills)
☐ Ecstasy	☐ Tranquilizers/Xanax	☐ Pain Killers	☐ Over the Counter

COURT ORDERED

Are services court ordered?	☐ Yes	☐ No
Are you under the Department of Corrections (DOC) Supervision?	☐ Yes	☐ No

MEDICAL

Do you have any medical issues or concerns?	☐ Yes	☐ No
If yes, please describe.		

Name of Doctor / Primary Care Provider	
Name of Clinic	
Phone Number	
Current Prescribed Medications	

Client Name:

GAIN SHORT SCREENING

TO BE COMPLETED BY YOUTH AGE 13 AND OLDER

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities or when they make you feel like you can't go on.

Please answer Yes or No.

During the past 12 months, have you had significant problems.....		
a. With feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	☐ Yes	☐ No
b. With sleep trouble such as bad dreams, sleeping restlessly or falling asleep during the day?	☐ Yes	☐ No
c. With feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	☐ Yes	☐ No
d. When something reminded you of the past, you because very distressed and upset?	☐ Yes	☐ No
e. With thinking about ending your life or committing suicide?	☐ Yes	☐ No
IDS Sub-Scale Score (0 to 5)		
During the past 12 months, did you do the following things two or more times?		
a. Lie or con to get things you wanted or to avoid having to do something?	☐ Yes	☐ No
b. Have a hard time paying attention at school, work or home?	☐ Yes	☐ No
c. Have a hard time listening to instructions at school, work or home?	☐ Yes	☐ No
d. Been a bully or threatened other people?	☐ Yes	☐ No
e. Start fights with other people?	☐ Yes	☐ No
EDS Sub-Scale Score (0 to 5)		
During the past 12 months did.....		
a. You use alcohol or drugs weekly?	☐ Yes	☐ No
b. You spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	☐ Yes	☐ No
c. You keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you in trouble with other people?	☐ Yes	☐ No
d. Your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school home, or social events?	☐ Yes	☐ No
e. You have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use and alcohol or drugs to stop being sick or avoid withdrawal	☐ Yes	☐ No
SDS Sub-Scale Score (0 to 5)		

Signature   Date