



For Office Use Only  
 Client ID: \_\_\_\_\_

999 164<sup>th</sup> Ave. NE, Bellevue, WA 98008  
 Phone: 425-747-4937  
 Confidential Fax: 425-957-0351

[www.youtheastsideservices.org](http://www.youtheastsideservices.org)  
 Bellevue • Kirkland • Redmond • Sammamish

**Information provided will be kept strictly CONFIDENTIAL!**

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



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**CLIENT NAME:**

<b>FINANCIAL SCREENING</b>					
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!					
<b>FINANCIALLY RESPONSIBLE PERSON(S)</b>					
First Name		Last Name			
Relationship to Client					
Billing Address					
City		Zip			
Phone		Message?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Alternate Phone		Message?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>PRIMARY INSURANCE</b> (If client has secondary coverage please complete secondary insurance form)					
Insurance Company Name					
Insured's Name					
Identification Number		Insured's Employer			
Clients Relation to Insured		Insurance Phone Number			
<b>SLIDING FEE SCALE</b>					
Number of people who live in your household?					
Number of people under 18 who live in your household?					
Annual Income					
<b>FINANCIAL ACKNOWLEDGMENTS &amp; CONSENT</b>					
<input type="checkbox"/> - I understand that I am fully responsible for ALL services not covered by my insurance.					
<input type="checkbox"/> - I understand that estimated benefits are NOT a guarantee of payment.					
<input type="checkbox"/> - I understand that YES will bill my insurance company at its established full fees (if applicable).					
<input type="checkbox"/> - I understand that payment is due when services are rendered.					
<input type="checkbox"/> - I understand I will be charged a \$20.00 NO SHOW fee for appointments cancelled less than 24 hours before the appointment.					
<input type="checkbox"/> - I agree to provide YES with a copy of my insurance card(s), photo identification and/or proof of income (if applicable)					
<input type="checkbox"/> - I agree to promptly notify the YES Billing Office if my insurance and/or financial circumstances change.					
<input type="checkbox"/> - 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. <b>I certify that I have read, understand and agree to the content of this agreement.</b>					
Client Signature					Date
Parent/Guardian Signature					Date



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CLIENT NAME:

**CURRENT CONCERNS** (What brings you to YES today?)

**CONCERNS & SYMPTOMS** (Check all that apply)

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

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

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Tobacco/Nicotine/Vaping	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Hallucinogens / LSD
<input type="checkbox"/> Heroin	<input type="checkbox"/> Methamphetamines	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Stimulants (Pills)
<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Tranquilizers/Xanax	<input type="checkbox"/> Pain Killers	<input type="checkbox"/> Over the Counter

**COURT ORDERED**

Are services court ordered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you under the Department of Corrections (DOC) Supervision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**MEDICAL**

Do you have any medical issues or concerns?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please describe.		
Name of Doctor / Primary Care Provider		
Name of Clinic	Phone Number	
Current Prescribed Medications		



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CLIENT NAME:

<b>GAIN SHORT SCREENING</b>		
<b>TO BE COMPLETED BY YOUTH AGE 13 AND OLDER</b>		
<p>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.</p> <p>Please answer Yes or No.</p>		
<b>During the past 12 months, have you had significant problems.....</b>		
a. With feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. With sleep trouble such as bad dreams, sleeping restlessly or falling asleep during the day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. With feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. When something reminded you of the past, you became very distressed and upset?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. With thinking about ending your life or committing suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IDS Sub-Scale Score (0 to 5)		
<b>During the past 12 months, did you do the following things two or more times?</b>		
a. Lie or con to get things you wanted or to avoid having to do something?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Have a hard time paying attention at school, work or home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Have a hard time listening to instructions at school, work or home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Been a bully or threatened other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Start fights with other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
EDS Sub-Scale Score (0 to 5)		
<b>During the past 12 months did.....</b>		
a. You use alcohol or drugs weekly?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SDS Sub-Scale Score (0 to 5)		
Signature	Date	