CLIENT INFORMATION FORM – MINOR CHILD

Client Name: _____ **(Nickname):** _____
First Middle Last

Client Address: _____
Street City State Zip

Mailing Address, if different: _____
P.O. Box / Street City State Zip

Cell Phone: _____ **Can we text you**? ☐ Yes ☐ No **Home Phone:** _____

Email: _____ **Appointment Reminder via:** ☐ Text ☐ Email ☐ Phone call

Sex: ☐ M ☐ F **SS#:** _____ **Date of Birth:** _____ **Age:** _____

Biological Father's Name: _____

Biological Mother's Name: _____

Marital Status of Biological Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Never married
☐ One parent deceased ☐ Father ☐ Mother ☐ Both parents deceased ☐ Living together
☐ Custodial parent remarried

****Note: In the case of divorce New Life Counseling will need a copy of the custody arrangements for your child. Do you have: Shared custody _____ Sole custody ____**

Non-custodial parent(s) (if applicable) names and ages: _____

Non-custodial parent(s) address:_____
Street City State Zip

Non-custodial parent(s) Home Phone:_____ **Work:**_____ **Cell:** _____

Non-custodial parent (s) current/ recent contact pattern with child? _____

_____

Would you like to be contacted if non-custodial parent requests information regarding your child's treatment ? ☐ Yes ☐ No

Child's School (if applicable): _____ **Grade:** _____

☐ IEP ☐ 504 ☐ Advocacy for IEP? ☐ Speech Therapy ☐ Occupational Therapy

Is your child involved with Juvenile Court? ☐ Yes ☐ No

Charges: ☐ D.V. ☐ Unruly ☐ Truancy ☐ Alcohol and/or Drugs ☐
Other: _____

CLINICAL INFORMATION: *Please fill in the following information as completely as possible. All information is covered by our confidentiality policy. Use a separate sheet of paper if necessary.*

Check current behavioral changes, concerns and symptoms:

❑ Hallucinations	❑ Anger	❑ Fear(s)	❑ Sleep Problems	❑ Nightmares
❑ Depressed Mood	❑ Irritability	❑ Poor Concentration	❑ Temper Outbursts	❑ Tired
❑ Suicidal Thoughts	❑ Panic Attacks	❑ Worry	❑ Stress	❑ Obsessive Thoughts
❑ Family Conflict	❑ Using Alcohol	❑ Using Illegal Drugs	❑ Hurting self	❑ Compulsive Behaviors

❑ Other behavioral changes (describe): _____

When did the above symptoms begin?_____

Some people desire faith-based elements incorporated in their treatment, is this something you are interested in? ☐ Yes ☐ No ☐ Doesn't matter

Please list any substances that you use. ***Include amount and frequency:***

Alcohol _____ Marijuana _____ Caffeine _____
Tobacco (cigarettes, etc.) _____ Heroin _____ Other _____
Psychedelics _____ Methamphetamine _____

****Do you have thoughts about hurting yourself or others?** ☐ No ☐ Yes **If yes, please describe.**

_____

Please complete other side

Please describe your goals for therapy:

A. _____

B. _____

Briefly describe your child's strengths and weaknesses:

_____

_____

Is your child currently on any medication? ☐ Yes ☐ No

Medication	Dosage	Prescribing Physician	Date Started

As a parent, do you support using a mental health medication if it would be helpful? ☐ Yes ☐ No

If no, please explain: _____

MEDICAL INFORMATION:

Primary Care Physician: _____ **Phone:**_____

Date of last exam: _____

Medical History. Please list major injuries, illnesses or surgeries:

Condition	Dates	Treatment

DEVELOPMENTAL INFORMATION:

List all household members (names, ages, and relationship to child): _____

_____

_____

List any siblings not living with the family (names and ages) : _____

_____

_____

FAMILY STRUCTURE HISTORY

Please list parents/step-parents/parent's significant others present in child's life in primary home.

Adults/ Guardians	Child's age start/ end	Why changed/ ended

What has the child's family been like growing up so far? For example instances of parental substance abuse, physical, verbal or sexual abuse issues, accidents, notable positive events, as well as other relevant life events: (Please note that if you provide information on child abuse we may be obligated to report that to the appropriate authorities):

_____

_____

Briefly describe your child's current support system (family, friends, organizations, self):

_____

_____

Was your child adopted? ☐ Yes ☐ No Date of Adoption: _____ Age at Adoption: _____

Please complete other side

Has your child ever received foster care? ☐ Yes ☐ No **Details:** _____

_____

_____

BILLING INFORMATION FOR MINORS

Mother Name: _____

Address:_____

Cell Phone: _____ **Can we text you**? ☐ Yes ☐ No **Home Phone:** _____

Email: _____ **Appointment Reminder via:** ☐ Text ☐ Email ☐ Phone call

SS#: _____ **Date of Birth:** _____

Employer: _____ **Work Phone**: _____

May we contact at work? ☐ Yes ☐ No

Father Name: _____

Address:_____

Cell Phone: _____ **Can we text you**? ☐ Yes ☐ No **Home Phone:** _____

Email: _____ **Appointment Reminder via:** ☐ Text ☐ Email ☐ Phone call

SS#: _____ **Date of Birth:** _____

Employer: _____ **Work Phone**: _____

May we contact at work? ☐ Yes ☐ No

MEMO OF UNDERSTANDING:

I understand that the hourly rate is $150 for the initial visit and $120 per therapy session thereafter. I understand that New Life Counseling will make every attempt to collect payment from my insurance company but that I am ultimately responsible for the balance on this account for any professional services received and that payment is due at the time of service. ***I understand that if I do not show for an appointment or cancel an appointment within 24 hours of my scheduled appointment time, I will be assessed a $75 fee that is not insurance billable or reimbursable***. I have read the Financial and Cancellation policies and agree to these conditions. I certify this information is true and correct to the best of my knowledge and will notify you of any changes.

INSURANCE INFORMATION:

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INSURED NAME: _____	INSURED NAME: _____
BIRTHDATE: _____	BIRTHDATE: _____
INSURANCE CO: _____	INSURANCE CO: _____
POLICY # _____	POLICY # _____
GROUP # _____	GROUP # _____
CLAIMS ADDRESS: _____	CLAIMS ADDRESS: _____
INS. CO. PHONE: _____	INS. CO. PHONE: _____

By signing below, I voluntarily consent for my minor child to be evaluated and seen in treatment by the clinical staff at New Life Counseling.

_____

Client Name (Print) Date Client Signature

_____

Custodial Parent / Guardian / Other (Print) Date Parent / Guardian / Other Signature.