CLIENT INFORMATION FORM – MINOR CHILD

**** PLEASE COMPLETE EACH AREA. ALL PAPERWORK MUST BE COMPLETED BEFORE ARRIVING FOR YOUR APPOINTMENT. INCOMPLETE PAPERWORK MAY RESULT IN NOT BEING SEEN AS SCHEDULED.**

Child's Name: _____ **(Nickname):** _____
First Middle Last

Child's Address: _____
Street City State Zip

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

Parent/Guardian Cell Phone: _____ **Can we text you**? □ Yes □ No **Cell Provider**_____
(AT&T, Sprint, Straight Talk, Verizon, etc)

Home Phone: _____ **Other:** _____ **Email:** _____

Appointment Reminder via: □ Email □ Phone call □ Text **Preferred number to call or text** □ Cell □ Home □ Other

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

Biological Father's Name: _____ Date of Birth:_____ SS#:_____

Biological Mother's Name: _____ Date of Birth:_____ SS#:_____

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

*****Note: In the case of divorce or separation, New Life Counseling will need a copy of the custody arrangements for your child.**

Do you have: Shared parenting_____ if no, Who is the CUSTODIAL parent _____
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
Name of Guardian (s)_____
Address and Phone number of Guardian:_____

School District Child attends: _____
Child's School: _____ **Grade:** _____
Is there any: □ IEP □ 504 □ Advocacy for IEP? □ Speech Therapy □ Occupational Therapy

Is your child involved with Juvenile Court? □ No □ Yes **Please indicate the nature of the involvement below**
Charges: □ D.V. □ Unruly □ Truancy □ Alcohol and/or Drugs □ Other: _____
_____

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

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

Have you or your child ever been subject to involvement with JFS or Child Protective Services? □ No □ Yes
If Yes, is this a current case? □ No □ Yes: If NO – What were the dates of your case (s) _____
If yes, what is the nature of your case?_____
_____
What is the name and telephone number of your case worker at JFS?_____

Is this child involved in any custody dispute? □ No □ Yes Have you been assigned a Guardian ad Litem?
□ No □ Yes - If yes, please provide the name and phone number:_____

Please complete other side

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.*

Please provide a description of what led you to seek counseling for your child:

_____

_____

_____

_____

_____

Check current behavioral changes, concerns and/or 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?_____

Please list any substances that the minor may/does use. *Include amount and frequency:*

Alcohol _____ Marijuana _____ Caffeine _____

Tobacco (cigarettes, etc.) _____ Heroin _____ Other _____

Psychedelics _____ Methamphetamine _____

****Does the child or do you, the minor, have thoughts about hurting yourself or others? □ No □ Yes**

If yes, please describe.

_____

_____

Please describe your goals for therapy:

A. _____

B. _____

Briefly describe your child's strengths and weaknesses:

_____

_____

Is your child currently on <u>any</u> medication? □ Yes □ No

Medication	Dosage	Prescribing Physician	Date Started

As a parent (guardian), 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

<u>Please complete other side</u>

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):

_____

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

PRIMARY CONTACT INFORMATION FOR MINORS

**** Mother/Guardian 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**: _____

**** Father/Guardian 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**: _____

EMERGENCY CONTACT INFORMTION - OTHER THAN PRIMARY PARENT(S) OR GUARDIAN

NAME	PHONE # / EMAIL	RELATIONSHIP TO CHILD

Please complete other side

LEGAL SITUATIONS

If you or the client (if the client is a minor or a ward of a guardian) become involved in legal proceedings that require your therapist's participation you will be expected to pay for all of their professional time, even if they are called to testify by another party. Your therapist will ask that a retainer be paid of the expected fees at least one or more weeks prior to providing these services. Your therapist's professional time for legal proceedings may include preparation (document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that they wait in court prior to or after they may be called to testify. Due to the time-consuming and often difficult nature of legal involvement, your therapist charges $300.00 per hour for these services. You will also be responsible for any legal fees that they may incur in connection with the legal proceeding, which may include responding to subpoenas. If we reserve time for testimony and you let us know more than a week in advance that we are no longer needed, all amounts will be refunded less the cost of time that could not be rescheduled.

MEMO OF UNDERSTANDING:

- *I voluntarily consent for my child to be seen in treatment by the clinical staff at New Life Counseling.*
- **I understand that I am responsible for all fees charged for services and understand that co-pays, deductibles or balances are due at the time the services are rendered.**
- I understand that if I have insurance, New Life Counseling will bill my insurance company and make every attempt to collect payment from my insurance company. **I understand that there are fees for services that may not be covered by insurance. An example of the fees not covered by insurance are phone calls with my clinician, reports or letters written by my clinician on my behalf, non-covered testing fees, and late cancel or no show fees.**
- I agree that if there is any change in my insurance that I will notify New Life Counseling immediately of those changes.
- **I agree to pay, at the time of service, for any fees that New Life Counseling cannot bill to insurance and I further understand that I am fully responsible for payment of any fees that my insurance company declines to reimburse.**
- *I understand that if I do not show for an appointment or if I 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 further acknowledge and understand that if applicable, custodial paperwork is required to be presented at the first appointment and that I agree to provide that paperwork and have brought it to this first appointment □ Yes*
- *I also understand that New Life Counseling will not bill any person other than the responsible party who brings the child in for the initial appointment and has signed all of the paperwork regardless of any court documents indicating responsibility of medical care costs between parents. All fees for services will be due at the time of service by the responsible party. It is the obligation of the responsible party to submit a record of payment of applicable fees and services to the other parent for reimbursement.*

Client Name (Print)	Name of Custodial Parent /Guardian /Other (Print)
Signature of Parent / Guardian / Other	Date Signed

Please complete other side