



NEW CLIENT DATA AND INFORMED CONSENT AGREEMENT FOR CHILDREN AND ADOLESCENTS
Under 18 years old

Today's Date \_\_\_\_\_
052006

Child/Adolescent Information

Child's Name \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ OK to call/lv.msg? Y / N Social Security Number: \_\_\_\_\_

Gender: M / F Religion: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

In emergency, contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

What concerns led to an appointment being scheduled for this child?

\_\_\_\_\_
\_\_\_\_\_

School Information

Currently attending school at: \_\_\_\_\_ Grade: \_\_\_\_\_

Special Class: \_\_\_\_\_ Best Subject: \_\_\_\_\_ Weakest Subject: \_\_\_\_\_

Teacher: \_\_\_\_\_ May I contact this person? Y N

Teacher: \_\_\_\_\_ May I contact this person? Y N

Guidance Counselor: \_\_\_\_\_ May I contact this person? Y N

Principal: \_\_\_\_\_ May I contact this person? Y N

Has this child:

- been retained / held back: Y N grade(s) \_\_\_\_\_
been in special classes Y N grade(s) \_\_\_\_\_
been diagnosed as learning disabled Y N by \_\_\_\_\_
been tested in school Y N grade(s) \_\_\_\_\_
been diagnosed as ADD / ADHD Y N by \_\_\_\_\_
change schools frequently Y N grade(s) \_\_\_\_\_

**FAMILY INFORMATION**

**Marital Status of Parents**

\_\_\_ Married (how long? \_\_\_\_\_) \_\_\_ Living together, not married \_\_\_ Single, never married  
\_\_\_ Engaged \_\_\_ Separated (how long? \_\_\_\_\_) \_\_\_ Divorced (how long? \_\_\_\_\_)

**Father's Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How long? \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Religion: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Number of prior marriages: \_\_\_\_\_ If divorced, how long? \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How long? \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Religion: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Number of prior marriages: \_\_\_\_\_ If divorced, how long? \_\_\_\_\_

**Relationship between parents:** good    strained    conflict    not speaking    no contact

**Who has primary custody of children?** \_\_\_\_\_

Named of other Children      Age    Sex    Relationship to client      Living at client's home?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the family's religion/faith? \_\_\_\_\_ Active in Church? \_\_\_\_\_

Family legal/financial problems (lawsuits, bankruptcy, foreclosure, medical bills, other bills, illnesses, deaths, recent moves etc.): \_\_\_\_\_

\_\_\_\_\_

**MEDICAL INFORMATION**

Family Physician: \_\_\_\_\_ Limited Release to Physician: \_\_\_yes \_\_\_no

Is the child currently on any medication? \_\_\_yes \_\_\_no If yes,

<u>Medication</u>	<u>Purpose</u>	<u>Dosage</u>	<u>How long?</u>	<u>Prescribed by</u>

List any medical conditions: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

How would you describe your child's physical health? Excellent Good Poor

Did the mother receive prenatal care? Y N Were there any concerns? \_\_\_\_\_

Was the delivery c-section or vaginal? \_\_\_\_\_ Have weight gain &amp; growth been normal? Y N

Hospitalizations: \_\_\_\_\_ Surgeries: \_\_\_\_\_

Health Concerns: Birth to 1 yr: \_\_\_\_\_ asthma: \_\_\_\_\_

1-3 years: \_\_\_\_\_ diabetes: \_\_\_\_\_

3-5 years: \_\_\_\_\_ G.I problems: \_\_\_\_\_

Vision impairment: \_\_\_\_\_ Hearing impairment: \_\_\_\_\_

Developmental Milestones: At what age did the child?

Sit alone: \_\_\_\_\_ Stand alone: \_\_\_\_\_

Walk: \_\_\_\_\_ Talk first words: \_\_\_\_\_

Speak in sentences: \_\_\_\_\_ Toilet train: \_\_\_\_\_

Ride a tricycle: \_\_\_\_\_ ride a bicycle: \_\_\_\_\_

**COUNSELING HISTORY**

Has the child ever been to counseling for any reason? Y N If yes, how long? \_\_\_\_\_

Briefly, what reason? \_\_\_\_\_

Is the child presently working with any other counselor/psychologist/etc.? Y N

Reason \_\_\_\_\_

Counselor's name: \_\_\_\_\_ Limited release to Counselor \_\_\_Y \_\_\_N

Who referred you here? \_\_\_\_\_ Limited release to Referral Source \_\_\_Y \_\_\_N

# ISSUES CHECKLIST

Circle any problems that apply to the child:

- Cleaning room    fears going to school    sulks bedtime    tries to be perfect
- suicidal talk    homework    feels inferior    talks to much    pet care    fights
- temper tantrums    poor appetite    loud/yells    eats to much    cheats    lies
- Wets bed    moody    soils self    immature    steals    truant    argues
- sexually preoccupied    runs away    nightmares    following directions    shy
- Sets fires    secretive    demands attention    fears/worries    no conscience
- too much guilt    forgetful    sad/depressed    restless/can't sit still

Other comments/issures: \_\_\_\_\_

How would your describe this child? \_\_\_\_\_

What does your child do for fun?

Hobbies: \_\_\_\_\_

Games: \_\_\_\_\_

Clubs: \_\_\_\_\_

Organizations: \_\_\_\_\_

Friends: \_\_\_\_\_

How would you describe the family? \_\_\_\_\_

If you are the parent, what are the good things about how you parent this child? \_\_\_\_\_

If you are the parent, what would you like to change about how you parent your child? \_\_\_\_\_

What did you learn about the ways in which your parents parented you? \_\_\_\_\_

**PAYMENT INFORMATION**

Treatment Fees will be paid by: \_\_\_\_\_ Telephone: \_\_\_\_\_

Are we filing with your insurance company? \_\_\_Y\_\_\_ N.

**If yes, you are responsible to know your policy provisions and coverage. You are also required to obtain all initial authorization. All unpaid fee will be your responsibility.**

Insurance Company: \_\_\_\_\_

**A copy of insurance card and Florida ID is required if we are to file with your insurance carrier**

Insured's Name: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's ID Number: \_\_\_\_\_

Insured's Group Number: \_\_\_\_\_ Yearly deductible: \_\_\_\_\_ Met? \_\_\_Y\_\_\_ N

Insured's Employer: \_\_\_\_\_ Limited Release to Insurance Company: \_\_\_Y\_\_\_ N

**Before you sign this form make sure that you've answered all required questions**

**CONSENT FOR TREATMENT AND TO PAYMENT PROCEDURE**

I consent to psychotherapeutic evaluation and treatment of this child. I have informed all other parent figures that I am seeking treatment for this child. I have received and read the Client Handbook and understand my rights and responsibilities and those of my counselor in this counseling relationship.

**I understand that fees for services rendered are expected on the day of appointment unless PRIOR arrangements have been made. Appointments cancelled without 24 hours advance notice and any no show will be charged half the standard rate.**

I hereby authorize payment directly to CORE Counseling Service, Inc. of any benefits specified and otherwise payable to me, but not to exceed the charges for services rendered. I authorize the release of information to process these claims.

The information I have given is true and complete.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_