**Minor Client Information**

Except in cases of child/elder abuse or immediate danger to yourself/others, all information provided will be kept strictly confidential and released only in accordance with professional ethics and applicable law.

Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_ Male Female

Parent/Guardian Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Single Married Re-married Divorced Widowed

If the rights of parent/guardian are determined by a court order, a copy of the most current legal custodial order is required prior to beginning services.

If parent is re-married, step parent name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (May call: yes/no Leave message: yes/no)

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (May call: yes/no Leave message: yes/no)

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (May call: yes/no Leave message: yes/no)

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Email: yes/no)

If an emergency arises and we must cancel your appointment, which is the best way for us to reach you?

 Home Work Cell Email

Employer-Mom\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer-Dad\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently in counseling elsewhere? Yes No

Has your child ever received counseling or evaluation services? Yes No

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you or your child ever been involved in any type of litigation? Yes No

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you seeking counseling or testing for your child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate the intensity of the problem or concern that brought you in?

 1 2 3 4 5

Not intense Moderate Extremely Intense

Approximately, how long have you noticed the problem/concern?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In what ways have you attempted to cope with this problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EMERGENCY CONTACT INFORMATION**

In the event of an emergency, I give you permission to contact:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name Relationship Phone

**FINANCIAL RESPONSIBILITY**

Who is financially responsible for this account? Self Other

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soc. Sec #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_

Complete if different from above:

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cash, checks, MasterCard, Visa, and Discover are accepted. Any unpaid balance may be turned over to a collection agency if there is an account balance. Payment is expected for late, cancelled, or forgotten appointments unless there has been an emergency or you have contacted Amy Curry to cancel 24 hours before your schedules appointment.

I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of patient or parent if minor Date

**ABOUT YOUR CHILD’S EDUCATION**

Age\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_\_\_Repeated Grades?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child receive special education services or 504 accommodations? Yes No

 If yes, what diagnosis did your child qualify for?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What age did you child begin receiving extra services?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times has your child changed schools and/or school districts?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What have school personnel said about your child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ABOUT YOUR CHILD’S FAMILY**

Please check any past, present, or impending special problems in your family:

 divorce frequent locations debilitating injuries/disabilities alcohol/drug abuse serious illness psychiatric disorder physical/sexual abuse financial crises legal problems eating disorders attempted/completed suicide

Have you personally experienced significant family abuse?

 None Unsure Emotional Physical Sexual

In general, how happy or adjusted were you growing up?

 Happy Average Not Happy

How much is your immediate family a source of emotional support for you?

 None Little Somewhat Substantial Very Strong

Child’s current household: Mother only Father only Biological parents

 Biological mother & Stepfather Biological father & Stepmother Adoptive parents

Grandparents Other relatives Foster family Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all who reside in the primary home with the child:

Name Role (i.e., parent, sibling) \_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If visitation applies for the child, please describe custody arrangements and how long current arrangements have been in place \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all who reside in a second household (if applicable)

Name Role (ie., step-parents, sibling) Date of Birth

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

Who in your family is your child closest to?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most distant from?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In most conflict with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any significant family members whom have died:

Name Role (i.e., parent, brother, grandmother) Date of Death/Age of Client

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

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**ABOUT YOUR CHILD’S ROUTINE**

What time does child your child wake-up?\_\_\_\_\_\_\_\_\_\_\_\_Go to sleep?\_\_\_\_\_\_\_\_\_

Teen’s curfew\_\_\_\_\_\_\_

What kinds of physical exercise does your child get?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much time does child spend watching T.V.daily?\_\_\_\_\_\_\_\_\_Playing video games? \_\_\_\_\_\_

How many servings of fruit and vegetables does your child consume each day?

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

Is your child’s diet restricted in any way? How? Why?

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

Does your child have scary dreams?\_\_\_\_\_\_\_

Please describe how often and in what form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have night terrors?\_\_\_\_\_\_\_\_

Please describe how often and how long does it last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ABOUT YOUR CHILD’S HEALTH**

Who is your child’s pediatrician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns shared by the doctor?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any allergies your child has:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medications your child takes or has taken in the last year (include prescribed and over-the counter)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all prior counselors, dates, seen, and reasons for counseling:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Starting with birth and proceeding to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you child has had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a history of mental illness in the child’s family? If so, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does any family member have a current or chronic illness? If so, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else you are concerned about?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**QUESTIONS IN REGARD TO OLDER CHILDREN**

Is your child in a gang? Yes No

Has your child used drugs? Yes No

Has your child ever been pregnant or fathered a child? Yes No

 If yes, please explain what happened:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENTAL STATUS INFORMATION**

Have you or your child ever attempted suicide or harmed yourself in any way? Yes No

Are you or your child currently thinking about suicide or

harming yourself in any way? Yes No

Have you or your child had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? Yes No

Are you or your child having any thoughts about harming

anyone else in any way? Yes No

**ABOUT YOUR CHILD’S SYMPTOMS**

Please mark all characteristics of concern that apply to your child.

 Aggressive Accident-Prone Argues

 Affectionate Anxious/Nervous Breaks rules/law

 Bullied by others Bullies others Cheats

 Clowns around Compliant Feels sick often

 Conflicts at school Conflicts at home Conflicts w/friends

 Cruel to animals Dawdles Dependent/clingy

 Depressed/Sad Destructive Delayed

 Disorganized Distractible/daydreams Disruptive

 Substance use Eating issues Failure in school

 Fearful/Shy Feelings hurt easily Fidgety

 Fights Sets fires Forgetful

 Hair chewing Head banging Hitting/biting

 Hostile Hyperactive Hypochondriac

 Imaginary playmates Immature Sexual behaviors

 Inattentive Independent Inflicts pain on others

 Insults others Interrupts Intimidated by others

 Irritable Isolates/withdraws Lacks concern for others

 Lacks motivation Learning disability Legal difficulties

 Lethargic Likes to be alone Loss of friends

 Low frustration Lying/manipulative Moody

 Mute Nail biting Needs much supervision

 Nightmares/Terrors Noisy Noncompliant

 Young playmates Outgoing Overly obedient

 Overly sensitive Picks on others Pouts

 Refuses Restless Rocking movements

 Runs away Self-harming Smokes

 Speech difficulties Suicide talk Stubborn

 Swearing Temper tantrums Tics-movement/noises

 Truancy Uncooperative Under-active

 Unhappy Violent Wets bed/clothes

Any other characteristics not listed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF UNDERSTANDING**

I solemnly swear that all of the above information is true to the best of my knowledge

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

Guardian’s Signature Date

**Amy Curry LCPC RPT at Meridian Counseling Center**

**Information Disclosure and Consent Form**

\* Amy Curry’s current rate is $125.00 and is not flexible according to insurance laws. Clients are to pay the fee at the beginning of every new session.

\* I understand that Amy Curry does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance.

\* I understand that during the time that we work together, we will meet weekly for approximately 50 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.

\* I understand that the purpose of counseling is to provide a non-judgmental, safe, and supportive environment for me to explore areas in my life through talk therapy.

\* I also understand our contact will be limited to counseling sessions except, only in case of emergency, you may call Amy Curry 208-949-5886.

\* I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and that specific results are not guaranteed although benefits are expected from counseling.

\* I understand that counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in your life perspectives and decisions. These changes could be temporarily distressing.

\* I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

\* I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protection of my confidentiality, and that Amy Curry does not initiate the greetings.

\* Should I believe that a referral is needed, Amy Curry will provide some alternatives including programs and/or people who may be able to assist me.

\* I understand that all fees for counseling are due at the beginning of each session. If I am late for an appointment, I must still pay for the full session.

\* I understand that if I do not show up for a scheduled appointment, without notifying Amy Curry, I will be charged a $20.00 fee.

\* I understand that the rate for all subsequent therapy services such as: attending parent/teacher conferences, attending ARD meetings, conducting classroom observations, participating in legal depositions, interactions with insurance companies, consultations with attorneys, etc. will be billed at $100.00 per hour.

\* I understand that should I subpoena Amy Curry as a factual case witness or involve her in any court-related processes, Amy Curry charges a retainer fee of $1,000.00, with an additional $120.00 every hour she is involved in legal depositions, case preparation, travel, and witness time. The party issuing the subpoena is responsible for the fee. Even though you are responsible for the testimony fee, it does not mean that Amy Curry’s testimony will be solely in your favor. Amy Curry can only testify to the facts of the case and to her professional opinion

\* I understand that if I do issue Amy Curry a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment.

\* I understand that if a check is returned, a processing fee of $25.00 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and $25.00 processing fee. After a returned check, the office of Amy Curry may require cash payment of future appointments.

\* I understand that if a returned check is not cleared up in 30 days, Amy Curry will file a suit with the Ada County District Attorney’s Office.

\* Documentation is maintained regarding the services I receive. I have the right to access my counseling records. These records are confidential and will not be released to outside parties without my written consent.

\* With my consent, insurance companies or other external agencies may receive information regarding my counseling for reimbursement purposes.

\* Amy Curry is required to adhere to the professional code of ethics adopted by the Idaho Counselor Licensing Board. The Idaho Counselor’s Licensing Board has the general responsibility of regulating the practice of licensed professional counselors. The licensure of any individual under the licensing laws of Idaho does not imply or constitute an endorsement of that counselor, nor guarantee the effectiveness of treatment. I may, at any time throughout my treatment, seek a second opinion.

\* Sexual intimacy between a counselor and client/patient is never appropriate, and should be reported to the Idaho Counselor Licensing Board.

\* You may choose to engage in electronic communications with your counselor. If you and your counselor choose to do so, it is important for you to note that confidentiality through electronic transmissions is difficult to guarantee. However, counselors will follow guidelines as outlined in the ACA Code of Ethics.

\* Initial complaints should be addressed with your counselor. As a client, you have the right to make complaints regarding ethical concerns to the Bureau of Occupational Licenses at 208.334.3233.

Risks and Benefits of Distance Counseling:

Some clients receive counseling using electronic delivery, such as Skype, Face Time or telephone. The benefit of this option is the ability to receive counseling in an area where no provider is available or when travel is prohibitive. The risks of telecommunication include: the risk of a technological failure, the speed of Wi-Fi or Internet, last-minute changes in personal schedules,

1. Signal failure. When a connection is lost, I will attempt to re-connect for 10 minutes. I will call your phone and explore alternate forms of communication, or, reschedule to continue.

2. Signal speed. Communication may be delayed due to the speed of the internet. If responses interrupt the content of messages, we will explore an alternate form of communication.

3. Unexpected schedule changes. If you are unable to keep an appointment, please call and leave a message, and I will return your call as soon as possible. If you are not available at the time of our session, I will wait for 10 minutes. Clients are expected to pay a late fee of $20 which will be added to the following session's fee.

Telehealth procedures:

Sessions will begin with a verification of identity, which may include your full name, date of birth, or phone number. In some cases a code word will be established to verify the identity of the client and counselor. No sessions will be recorded without the specific consent of the client. If the session is limited to the telephone where no visual cues are apparent, the counselor will have a greater dependence on the tone of voice and quality of speech. When necessary, the counselor will ask clarifying questions to improve understanding and treatment.

Thank you for your strength in seeking counseling for your specific needs. I hope to be able to assist you in this journey. Please sign this sheet to indicate that you have read the information and understand your rights as a client. Also by signing this you are stating that you were given the opportunity to ask any questions regarding the above presented information and that you have agreed to receive counseling services from me.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature Date

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

Counselors Signature Date

Notice of Privacy Practice, 2013. Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights: **You have the right to:** Get a copy of your paper or electronic medical record. Correct your paper or electronic medical record. Request confidential communication. Ask us to limit the information we share. Get a list of those with whom we’ve shared your information. Get a copy of this privacy notice. Choose someone to act for you. File a complaint if you believe your privacy rights have been violated.

# Your Choices: You have some choices in the way that we use and share information as we: Talk with your family about your condition (as needed). Provide disaster relief. Provide mental health care.

# Our Uses and Disclosures: We may use and share your information as we:

|  |
| --- |
| * Treat you
* Run our organization
* Bill for your services
* Help with public health and safety issues
* Do research
* Comply with the law
* Address workers’ compensation, law enforcement, and other government requests
* Respond to lawsuits and legal actions
 |

# Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

* You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

* You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communications**

* You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

**Ask us to limit what we use or share**

* You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
* If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

**Get a list of those with whom we’ve shared information**

* You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
* We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
* We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

* You can complain if you feel we have violated your rights by contacting us using the information on page 1.
* You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.** We will not retaliate against you for filing a complaint.

# Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

* Share information with your family, close friends, or others involved in your care
* Share information in a disaster relief situation

In these cases we never share your information unless you give us written permission:

* Marketing purposes
* Most sharing of psychotherapy notes

# Our Uses and Disclosures: we never market or sell personal information

## How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Treat you:** We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

**Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

## How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**Help with public health and safety issues:** We can share health information about you for certain situations such as:

* Preventing disease
* Helping with product recalls
* Reporting adverse reactions to medications
* Reporting suspected abuse, neglect, or domestic violence
* Preventing or reducing a serious threat to anyone’s health or safety

**Do research:** We can use or share your information for health research.

**Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Address workers’ compensation, law enforcement, and other government requests:** We can use or share health information about you:

* For workers’ compensation claims
* For law enforcement purposes or with a law enforcement official
* With health oversight agencies for activities authorized by law
* For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

# Our Responsibilities

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. **See Attached Informed Consent for further details about confidentiality and client information. Please ask questions if desiring further information.**

Client Signature Date

**MINOR DEPENDENT CONSENT FOR OFF SITE ACTIVITY**

Amy Curry from Curry Counseling LLC requests your agreement for the client to participate in this off site activity: going for a walk.

While we recognize there is always some risk of harm during such an activity, we do not expect any adverse events of experiences.

**Please check the box indicating your agreement then sign and date below.**

\_\_\_\_\_ I, as Client’s Guardian, AGREE to allow client to participate in this off site activity. I fully and completely release and hold harmless Amy Curry, for any damages and/or injury whatsoever, including to the full extent allowed by law, liability which may result from client’s participation in this activity. I the undersigned, consent to emergency medical treatment for client as deemed necessary and or advisable in the judgment of Amy Curry and/or the examining physician.

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

Guardian Signature Date

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# Insurance Information Sheet

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male Female

Client Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Insured: Self  Spouse  Child  Other  Client Status: Part A: Single  Married  Other 

 Part B: Employed  Full-Time Student  Part-time Student 

**Is the client’s condition related to**: Employment YES  NO  Auto Accident YES  NO  Other Accident YES  NO

Insured’s Name (as appear on insurance card)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male Female

Insured’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Only list if different from client)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Only list if different from client)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: Yes No If yes, list company name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible $\_\_\_\_\_\_\_\_Amount met $\_\_\_\_\_ Copay $\_\_\_\_\_\_ # of allowed visits\_\_\_\_\_

I, as a Client or Insured Family Member, give consent and acknowledgement that this and other client information

 will be released to Insurance Carriers or Medicaid Agencies that provide financial reimbursement for requested

services of Amy Curry at Meridian Counseling Center:

Client’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Family Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_