Child Information Packet

Client _____

Counselor _____

This packet includes:

Document	Directions
Confidential Child Information	Complete and bring to first appointment
Policies & Procedures	Complete and bring to first appointment

Confidential Child Information

PARENT INFORMATION

Name: _____Age ___ DOB _____ SS # _____

Address _____City_____ State___ Zip _____

Home phone ( ) _____ Business ( ) _____ Cell Phone ( ) _____

Where do you prefer to receive calls? _____Home _____Work _____Cell Phone

Can we leave a message at this number? _____Yes _____ No

Marital Status: Single _____ Married _____ Separated _____ Divorced _____Widowed _____

Length of Marriage: Current: _____years Number & Length of other marriages: _____

Employer _____ Phone_____

Spouse: _____Age __ DOB _____

Address _____City _____ State _____ Zip _____

Home phone ( ) _____ Business ( ) _____ Cell Phone ( ) _____

Where do you prefer to receive calls? ____Home _____Work _____ Cell Phone

Can we leave a message at this number? _____Yes _____ No

Employer _____Phone_____

CHILD INFORMATION:

Name: _____ _ Sex: M___ F__ Birth Date_____

SS#_____

Address_____

City_____ State___ Zip_____

Education (grade)_____ Present school_____

Siblings (Name/Age) _____

PSYCHOSOCIAL HISTORY:

Current Family Situation:

Mother – **Relationship to child** ___ natural parent __ relative __adoptive parent __step-parent

Occupation _____

Highest level of education _____

Father – **Relationship to child** ___ natural parent __ relative ___adoptive parent ___step-parent

Occupation_____

Highest level of education_____

Marital History of Parents:

Natural Parents: _____ Married when _____ `

_____ Separated when _____

_____ Divorced when _____

_____ Deceased M or F _____

Step-parents: _____ Married when _____

Is there an ongoing custody battle for child? _ Yes _ No

Who has primary custody of child?

Are you required by a court or probation/parole officer to have this appointment?

_Yes _No

If child is adopted:

Adoption source: _____

Reason and circumstances: _____

Age when child first in home:_____

Date of legal adoption: _____

What has the child been told? _____

CHIEF COMPLAINT:

Presenting problems: (check all that apply)

___ Very unhappy	___ Impulsive	____ Fire setting
___ Irritable	___ Stubborn	___ Stealing
___ Temper outbursts	___ Disobedience	___ Lying
___ Withdrawn	___ Infantile	___ Sexual trouble
___ Daydreaming	___ Mean to others	___ School performance
___ Fearful	___ Destructive	___ Truancy
___ Clumsy	___ Trouble with the Law	___ Bed wetting
___ Overactive	___ Running away	___ Soiled pants
___ Slow	___ Self-mutilating	___ Eating problems
___ Short attention span	___ Head banging	___ Sleeping problems
___ Distractible	___ Rocking	___ Sickly
___ Lacks initiative	___ Shy	___ Drugs
___ Undependable	___ Strange behavior	___ Alcohol use
___ Peer conflict	___ Strange thoughts	___ Suicide talk
___ Phobic		

Explain: _____

_____

Problems perceived to be: ____ very serious ____ serious _____not serious

How long have these problems occurred? (Number of weeks, months, years) _____

What happened that makes you seek help at this time? _____

What are your expectations of your child? _____

What changes would you like to see in your child? _____

What changes would you like to see in yourself? _____

What changes would you like to see in your family? _____

CHILD HEALTH INFORMATION

Note all health problems the child has had or has now.

	AGE		**AGE**
___ High fevers	____	___ Dental Problems	_____
___ Pneumonia	____	___ Weight	____
___ Flu	____	___ Allergies	____
___ Encephalitis	____	___ Skin Problems	____
___ Meningitis	____	___ Asthma	____
___ Convulsions	____	___ Headaches	____
___ Unconsciousness	____	___Stomach Problems	____
___ Concussions	____	___ Accident	____
___ Head Injury	____	___ Anemia	____
___ Fainting	____	___ High/Low Blood Pres.	____
___ Dizziness	____	___ Sinus Problems	____
___ Tonsils Out	____	___ Heart Problems	____
___ Vision Problems	____	___ Hyperactivity	____
___ Hearing Problems	____	___ Other Illnesses, etc.	____
___ Earaches	____	(Explain	

Has the child ever been hospitalized? ____Yes ____ No

Age: _____

How Long: _____

Reason: _____

Has child ever been seen by a medical specialist? ____Yes ____ No

Age: _____

How Long: _____

Reason: _____

Has child ever taken, or is he/she presently any prescribed medications? ____Yes ____ No

Age: _____

How Long: _____

Reason: _____

Name of Primary Care Physician _____

Please list all medications your child is currently taking _____

_____

_____

Has child ever received counseling services before? __Yes __No

When? **How long** **Form whom?** **City/State**

_____

_____

_____

_____

Has child ever attempted suicide before? _Yes _No

Is child currently suicidal? _Yes _No

Does child have suicidal plan? _ Yes _ No

Has child ever self-injured? _ Yes _ No

DEVELOPMENTAL HISTORY

Prenatal – Child wanted? ____Yes ____No **Planned for?** ____Yes ____No

Normal pregnancy? ____Yes ____No

If mother ill or upset during pregnancy, explain: _____

_____

Length of pregnancy: _____

Paternal support and acceptance: (explain) _____

BIRTH

Length of active labor: hrs. Easy Difficult

Full term: Yes No

If premature, how early:

If overdue, how late:

Birth weight: lbs. oz.

Type of delivery: ___ spontaneous ___cesarean ___with instruments ___Head first ___breech

Was it necessary to give the infant oxygen? ____Yes ____No If yes, how long

Did infant require blood transfusions? ____Yes ____No

Did infant require X-ray? ____Yes ____No

Physical condition of infant at birth:

(If yes explain) Anorexia ____Yes ____No

Trauma ____Yes ____No

Other complications ____Yes ____No

_____

Did mother abuse alcohol/drugs during pregnancy? ____Yes ____No

NEWBORN PERIOD: how long

Irritability	____ Yes	____ No	_____
Vomiting	____ Yes	____ No	_____
Difficulty breathing	____ Yes	____ No	_____
Difficulty sleeping	____ Yes	____ No	_____
Convulsions/twitching	____ Yes	____ No	_____
Colic	____ Yes	____ No	_____
Normal weight gain	____ Yes	____ No	_____
Was child breast fed	____ Yes	____ No	_____

DEVELOPMENTAL MILESTONES:

Age at which child:

Sat up:	_____	Sentences:	_____
Crawled:	_____	Bladder trained:	_____
Walked:	_____	Bowel trained:	_____
Spoke single words:	_____	Weaned:	_____

Describe the manner in which toilet training was accomplished: _____

EARLY SOCIAL DEVELOPMENT:
Relationship to siblings and peers:

_____ Individual play _____ group play

_____ Competitive _____ cooperative

_____Leadership role _____a follower

Describe special habits, fears, or idiosyncrasies of the child: _____

_____

_____

EDUCATIONAL HISTORY:

Preschool:

Name of school _____

City/State _____

Dates attended: from _____ to _____

Grades completed: _____

Elementary:

Name of school _____

City/State _____

Dates attended: from _____ to _____

Grades completed: _____

Junior High:

Name of school _____

City/State _____

Dates attended: from _____ to _____

Grades completed: _____

High School:

Name of school _____

City/State _____

Dates attended: from _____ to _____

Grades completed: _____

Types of classes: _____Regular _____ Learning disability _____ Continuation

_____ Emotionally handicapped _____Opportunity ____ Other

Did child skip a grade? _____Yes _____ No

Repeat a grade? _____Yes _____ No

(If yes, when and how many years appropriate grade level at present time?) _____

ACADEMIC PERFORMANCE:

Highest grade on last report card _____

Lowest grade on last report card _____

Favorite subject _____

Least favorite subject _____

Does child participate in extracurricular activities? _____Yes _____ No

Explain _____

In school, how many friends does child have? ___ A lot _____a few ____ none

What are child's educational aspirations?

_____ Quit school

_____ Graduate from high school

_____ Go to college

Has child had special testing in school? (If yes, what were the results?)

Psychological _____Yes _____ No

Vocational _____Yes _____ No

List child's special interests, hobbies, skills: _____

_____

Has child ever had difficulty with the police? ____Yes ____No

(If yes, explain) _____

Has child ever appeared in juvenile court? ____Yes ____No

(If yes, explain) _____

Has child ever been on probation? ____Yes ____No

(If yes, explain) _____

From/To _____

Reason _____

Probation Officer _____

COUNSELING SERVICES

After the initial evaluation, you and your counselor will decide if he/she is the best person to provide the services which you need in order to meet your treatment objectives. If you choose to continue, your counselor will work with you to determine your treatment plan. Counseling is a process in which the client and counselor work together to help solve problems, explore feelings and work towards goals. In order for this to be successful, you will need to work on goals or assignments between sessions.

Please note that it is impossible to guarantee any specific results regarding your counseling goals; however, together we will work to achieve the best possible results for you. Respect, cooperation, and professionalism will characterize this therapeutic relationship at all times. Some clients may need only a few sessions to achieve their goals; whereas, others may choose to come for an extended period of time.

As a client, you are in complete control and may end the counseling relationship at any point.

CONFIDENTIALITY

In general, the confidentiality of all communications between a client and the counselor is protected by law, and information cannot be released without your written permission.

However there are some exceptions:

You sign a release directing disclosure of information to another professional or to someone else of your choosing.

If you choose to file insurance, your insurance company may have access to your records. Insurance companies usually require a specific clinical diagnosis, determined by the therapist, when claims are filed for mental health services. This diagnosis most likely will become a permanent part of your record. We cannot guarantee that our services will be covered by your policy or insurance company.

A court of law by a subpoena may under certain circumstances require the counselor to testify and/or release client files. It is our policy NOT to be involved in legal issues. If you have knowledge that your case is or may lead to a legal issue, we will make an appropriate professional referral. However, if a counselor receives a subpoena involving you, you will be responsible to pay $150.00 per hour for the time and expense spent in responding to the subpoena.

In accordance with the highest of ethical standards and with accordance to state and federal law, if a client intends to take harmful or dangerous action against another human being or against himself/herself, a counselor has a duty to warn:

1. Appropriate state or local agencies
2. The person who is likely to suffer the result of harmful behavior,
3. The family of the person who is likely to suffer the result of the harmful behavior,
4. The family of the client who intends to harm himself/herself,

In cases of **suspected or known** past or current abuse/neglect against a **minor child or elderly person,** the counselor has a responsibility to notify appropriate authorities (such as Child Protective Services).

Your counselor may consult with another professional on your case. Every attempt will be made to ensure that your identity will remain anonymous. The professional who is consulted is held to the same limits of confidentiality outlined here.

- **Please discuss with your counselor any questions or concerns you may have regarding the limits to confidentiality.**

FINANCIAL POLICY

- The fee for a 45-minute session is $110.00.
- FULL Payment is required at the time services are rendered and is the responsibility of the client or guarantor.
- Please discuss the possibility of alternative fee arrangements if the cost would prevent you from coming.
- **Refined Strength Counseling (RSC)** does not currently participate in managed care agreements with insurance companies. We will provide you with a **RSC** invoice **for you to submit to your provider** for reimbursement to you. The full payment is due at the time of service even if you are going to file with a third party.
- Please initial here _____ to state that you agree with the terms of our financial policies.

APPOINTMENTS

Counseling sessions are 45-50 minutes. For counseling to be effective several things are required among which are commitment to the process through faithfully attending appointments; completing "homework assignments" between sessions; establishing clearly defined goals (the counselor will help do this in the first session);

- Please be on time for your appointment and have all necessary paperwork completed
- All cancellations must be made at least 24 hours prior to your scheduled appointment time.
- Cancellations with less than 24 hours' notice will be charged one half of your counselor's normal fee.

PERMISSION FOR PROFESSIONAL SERVICES FOR A MINOR

Children over the age of 16 are considered legal adults when involved in mental health services. Confidentiality in these situations is restricted by the same laws that apply to adults. Before the age of 16, communication of confidential information between counselor, client and parents or legal guardians is at the discretion of the counselor.

Parents of children 15 years and younger should remain in the building and in close proximity to the counseling office during the counseling session. Please notify us if you must leave the building for any reason and leave a cell number to contact you. All parents/legal guardians of children **17 years and younger please read and sign.**

I have the legal authority to seek and grant permission for professional services for my minor child _____, birth date __/__/___, there being no legal decree disallowing my authority to assume such responsibility,

_____.

(Parent/legal guardian signature)

CONSENT FOR COUNSELING

I have read and understand the policies and procedures of Refined Strength Counseling regarding the Counseling Services, Financial Policy, Appointments, Confidentiality and Permission for Professional Services for a Minor. All adult members of your family who are involved in this counseling need to sign below, indicating understanding of these policies and procedures.

Client Signatures: _____ Date: _____

Client Signatures: _____ Date: _____

Counselor's Signature: _____ Date: _____