



NEW CLIENT INFORMATION – Minor Assessment

Date: ___/___/___

Client Name: _____ Date of Birth: ___/___/___

Sex: Female Male Custodial Parent(s)/Guardian(s): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we contact you and leave messages at these phone numbers? Yes No

Email: _____ May we email information to you? Yes No

Home Address: _____
(Street) (City) (State) (Zip Code)

May we mail information to this address: Yes No

If “no” please give mailing address: _____

Client School: _____ Grade: _____

Teacher(s): _____

Who may we thank for referring you? _____

Primary concern: _____

Who is your child’s physician? _____ Date of last physical exam: _____

Current medications: _____

FINANCIALLY RESPONSIBLE PARTY

Name: _____ Date of Birth: ___/___/___

Sex: Female Male Marital Status: Single Married Other

Employer: _____ Occupation: _____

Home Address (if different): _____
(Street) (City) (State) (Zip Code)

Contact Number (if different): _____ Social Security #: ___/___/___

ADDITIONAL INFORMATION

Family

<i>Relationship</i>	<i>Name</i>	<i>Age</i>	<i>Current Occupation/Employer</i>	<i>Highest level of education completed</i>
Mother				
Father				
Step-Mother				
Step-Father				
Sibling				
Sibling				
Sibling				
Sibling				

Who currently resides in the household with your child? _____

Please elaborate on any living situation other than biological parents still married: _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.).

<u>Condition</u>	<input type="radio"/> yes	<input type="radio"/> no	<u>Family member</u>
Alcohol/Substance Abuse	<input type="radio"/>	<input type="radio"/>	_____
Anxiety	<input type="radio"/>	<input type="radio"/>	_____
AD/HD	<input type="radio"/>	<input type="radio"/>	_____
Depression	<input type="radio"/>	<input type="radio"/>	_____
Domestic Violence	<input type="radio"/>	<input type="radio"/>	_____
Eating Disorders	<input type="radio"/>	<input type="radio"/>	_____
Obesity	<input type="radio"/>	<input type="radio"/>	_____
Obsessive Compulsive Disorder	<input type="radio"/>	<input type="radio"/>	_____
Schizophrenia	<input type="radio"/>	<input type="radio"/>	_____
Suicide Attempts	<input type="radio"/>	<input type="radio"/>	_____

Education

Please list **where** your child went to school and **describe his/her experiences**. Please include specific institution **names, locations and dates/ages** when known. **BE AS THOROUGH AS POSSIBLE.**

EARLY CHILD CARE: _____

PRESCHOOL: _____

ELEMENTARY SCHOOL: _____

JUNIOR HIGH SCHOOL: _____

HIGH SCHOOL: _____

Health/History

How would you rate your child's current physical health? (please select one)

- Poor Unsatisfactory Satisfactory Good Excellent

Please list any specific health problems your child is currently experiencing: _____

Were there any problems during pregnancy or birth? Yes No

If yes, please describe: _____

Was your child born full term, after 9 months of pregnancy? Yes No Birth Weight: _____

If no, please elaborate: _____

Please describe your child's sleep patterns as an infant: _____

Do you feel your child developed normally the first two years of life? Yes No

What age were the following milestones achieved? Crawled: _____ Walked: _____ First word: _____

Spoke in phrases: _____ Toilet trained: _____ Remained clean/dry all night: _____ Attended daycare: _____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Yes No If yes, when? _____

If yes, please list name(s) of past/current therapist/practitioner and issues child was seen for: _____

Has your child ever been prescribed psychiatric medication? Yes No

If yes, please list which medications/when prescribed: _____

Is your child taking any over-the-counter medication (vitamins, allergy medication, etc.)? Yes No

If yes, please list: _____

Does your child have any past medical problems? Yes No

If yes, please describe: _____

Has your child had any injuries such as broken bones or head injuries? Yes No

If yes, please describe: _____

Does your child have any allergies? Yes No

If yes, please describe: _____

Does your child have any problems with vision or hearing? Yes No

If yes, please describe: _____

How many times per week does your child generally exercise? _____

What types of exercise does he/she participate in? _____

Please list any difficulties your child is experiencing with appetite or eating patterns: _____

How would you rate your child's current sleeping habits? (please select one)

Poor Unsatisfactory Satisfactory Good Excellent

Please list any specific sleep problems he/she is currently experiencing: _____

Usual Bedtime: _____ How long to fall asleep? _____

Does your child sleep through the night? Yes No

If he/she wakes, how long does it take to fall back asleep? _____

Does your child often take naps? Yes No

Does your child have difficulty getting up in the morning? Yes No

Is your child currently experiencing overwhelming sadness, grief or depression? Yes No

If yes, for approximately how long? _____

Is your child currently experiencing anxiety, panic attacks or have any phobias? Yes No

If yes, when did he/she begin experiencing this? _____

Is your child currently experiencing any chronic pain? Yes No

If yes, please describe: _____

Has your child had any previous involvement with the police or the courts? Yes No

If yes, please describe: _____

What significant life changes or stressful events has your child experienced recently? _____

What prompted you to initiate AD/HD testing for your child? _____

Please respond regarding your child's behavior:	Yes	No
Deliberately annoys people		
Blames others for his/her mistakes or misbehavior		
Is angry or resentful		
Is spiteful or vindictive		
Asks continuous questions		
Often bullies, threatens, or intimidates others		
Often initiates physical fights		
Used a weapon that can cause serious physical harm to others (e.g. bat, brick, knife, gun)		
Has been physically cruel to people		
Has been physically cruel to animals		
Has stolen while confronting a victim (e.g. mugging, purse snatching, extortion)		
Has forced someone into sexual activity		
Has deliberately engaged in fire setting with the intention of causing serious damage		
Has deliberately destroyed others property		
Has broken into someone else's house, building, or car		
Often lies to obtain goods or favors, or to avoid obligations		
Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, forgery)		
Often stays out at night despite parental prohibitions		
Has run away from home overnight at least twice		
Is often truant from school		

Parent signature

Date

CONFIDENTIALITY STATEMENT

All information shared in this treatment is confidential except in circumstances governed by law. If you would like us to confer with another healthcare professional, school, attorney or any one else pertaining to the client, you will need to sign a "Release of Information" form. Both parties agree to take all reasonable measure to ensure confidentiality with any communication over the telephone and/or Internet.

CONSENT TO AUDIO/VIDEO RECORDING

The undersigned understands that sessions for assessments and evaluations may be audio recorded or video taped for note-taking purposes only. The audio/video will be stored in a locked cabinet and is subject to the same degree of confidentiality and security as medical records. If you do not agree to taping and/or recording of any sessions with the clinician, you will need to advise the clinician before the session begins. If you consent to audio/video recording, please initial to the right. **INITIAL _____**

FINANCIAL AGREEMENT

The fee for the assessment is \$_____, your initial payment is \$_____ and the final payment is \$_____. Additional professional services rendered at your request, such as phone contact over 5 minutes, consults with other professionals, preparation of special forms, reports, letters, etc. will be billed at the rate of \$140.00 per hour. If additional copies of the report are requested by the client, or on behalf of the client, there will be a fee of \$25 per report. If we are involved in any legal endeavors on your behalf and/or are subpoenaed, there will be an upfront payment of \$200 per hour. Assessments for minors in preschool and elementary school may include a consultation with the child's teacher. Please note that while the consultation is included in the assessment fee, additional charges may apply for transportation time to schools that are outside of a 15-mile radius of Stone Creek Psychotherapy. **INITIAL _____**

NO-SHOW/LATE CANCELLATION POLICY

Your visit has been reserved for you. 48 business hours' notice is required to give us ample time to fill your appointment. If you do not cancel prior to 48 business hours there will be a no show/late cancel fee of \$130.00 per hour. Please note that reminders are sent by our administrative staff to assist you in remembering your appointment, but are done as a courtesy and should not be relied upon. Absence of a reminder from our office does not relieve you of your responsibility to adhere to the cancellation policy. **INITIAL _____**

PAST DUE BALANCE

The undersigned understands and agrees to accept full financial responsibility for all charges. The clinician reserves the right to collect payment from the client and/or client's guarantor. Should the account be referred to an attorney or collection agency, the undersigned will be responsible for actual attorney fees and/or collection expenses.

CREDIT CARD INFORMATION: Credit Card Visa MasterCard

I authorize **Stone Creek Psychotherapy** to keep my signature on file and to charge my account for recurring charges, on-going treatment and account balances. I understand that this form is valid for 4 years unless I cancel through written notice to the health care provider.

Client's Name: _____ Card Holder's Name: _____

Credit Card #: _____ Exp. Date: ____/____ 3-digit CVD code: _____

Signature: _____

Payment is due before each session. Fees are subject to change

NOTICE OF PRIVACY PRACTICE

The notice in our waiting area describes how psychological and health information about you may be used and disclosed and how you can get access to this information.

I have read and received (if requested) and understand the privacy practices information. I understand that my signature on this form acknowledges receipt of these documents and acceptance of the conditions of the privacy policies of Stone Creek Psychotherapy and Wellness Center.

STATEMENT OF UNDERSTANDING:

I have read and understand this information sheet and informed consent.

Client Name (please print)

Date

Parent/Guardian's Signature

Date

Witness

Date

Regarding release of mental health medical records for adults and minors:

Texas Health and Safety Code, Chapter 611, Mental Health records, specifically Sections:

611.0045 (c) If the professional denies access to any portion of a record, the professional shall give the patient a signed and dated written statement that having access to the records **would be harmful to the patient's physical, mental, or emotional health** and shall include a copy of the written statement in the patient's records.

INITIALS _____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize _____,
Parent/Guardian Therapist's Name
regarding, _____.
Minor Client

Mark the one(s) that apply to you:

- To disclose and discuss financial and scheduling information to anyone who is or may be responsible for payment of all or a portion of the charge. INITIAL _____

- To disclose and discuss clinical and treatment information with _____.
Other Mental Health Provider's Name OR Attorney/Law Firm

- To exchange clinical information, such as diagnosis, treatment goals, and medication issues with my physician, _____, for the purpose of treatment planning and coordination.
Client's Physician's Name
Contact phone number and address: _____

- To disclose and discuss clinical and treatment information with, _____ and/or _____.
School Name Counselor(s) /Teacher(s)

- To disclose and discuss clinical and treatment information with, _____ please explain: _____
Other

- I prefer that no clinical and/or medical information be released at this time.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall remain in effect unless revoked or replaced. Specification of the date, event or condition upon which consent expires: _____

Client Name (Please print)

Witness

Parent/Guardian's Signature

Date

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a voice message) 48 hours before your scheduled appointments.

Client name: _____

Your name: _____

Your email address: _____

Your home phone number: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (please check **only one**)

Via a text message on my cell phone (normal text message rates will apply)

Via an email message to the address listed above

Via an automated telephone message to my home phone

None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature

Date