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

Who currently resides in the household with your child? ____

____

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

____

Family

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

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.).

Condition			Family member
Alcohol/Substance Abuse	◯ yes	◯ no	________________
Anxiety	◯ yes	◯ no	________________
AD/HD	◯ yes	◯ no	________________
Depression	◯ yes	◯ no	________________
Domestic Violence	◯ yes	◯ no	________________
Eating Disorders	◯ yes	◯ no	________________
Obesity	◯ yes	◯ no	________________
Obsessive Compulsive Disorder	◯ yes	◯ no	________________
Schizophrenia	◯ yes	◯ no	________________
Suicide Attempts	◯ yes	◯ no	________________

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/Developmental 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

CONSENT TO AUDIO/VIDEO RECORDING

The undersigned understands that sessions for assessments and evaluations may be audio recorded or videotaped 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: _____________________________________

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.

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 anyone 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.

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 Stone Creek Psychotherapy & Wellness Center
Parent/Guardian

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.

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Signature Date

updated 03/18