

Client Information/Child & Adolescent

Revised 12/11

Client Name: _____ Gender: M F

Date of Birth: _____ Age: _____ SS#: _____

Parents' Marital Status: _____

Custody Arrangements:
Please supply your therapist with copies of legal documentation related to custody.

Mother's Name: _____ Father's Name: _____

DOB: _____ Age: _____ DOB: _____ Age: _____

Occupation: _____ Occupation: _____

Marital Status: _____ Education: _____ Marital Status: _____ Education: _____

Mailing Address: _____ Mailing Address: same

Home Phone: _____ Home Phone: _____

Okay to leave message?
Voice Mail/ Answering Machine Yes No Initials: _____
With household member Yes No Initials: _____

When leaving messages we will identify our names rather than identifying ourselves as Counseling Associates.

Cell Phone: _____ Cell Phone: _____

Please note: While cell phone security continues to improve, the confidentiality of cell phone communication cannot be insured to the same degree as the use of land lines. Do you wish to have your cell phone(s) used? Yes No Initials: _____

Work Phone: _____ Work Phone: _____

Employer: _____ Employer: _____

Okay to contact at work? Yes No Initials: _____ *Okay to contact at work?* Yes No Initials: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____

Does Counseling Associates have your permission to use this contact information in the case of emergency? Yes No Initials: _____

Client referred by: _____



I understand that I am responsible for charges incurred that are not covered by my insurance. I understand that I am responsible for understanding my coverage and for knowing when the limits of my coverage are being exceeded. I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits to Counseling Associates of New London, PLLC, Counseling Associates of Newport, & Counseling Associates of Claremont. A copy of this signature is as valid as the original.

Signature	Date
Witness	Date

RESPONSIBLE PARTY TO WHOM STATEMENTS WILL BE SENT:

Name:	Relationship:
Mailing Address: <input type="checkbox"/> <i>contact information provided prior</i>	
Phone:	

Primary Insurance Company: *Please provide your insurance card for copying.*

Insurance Company:		
Subscriber ID:		Group #:
Subscriber Name:		Employer:
Social Security #:	DOB:	Relationship to Client:

Secondary Insurance Information: *Please provide your insurance card for copying.*

Subscriber Name:		Employer:
Social Security#:	DOB:	Relationship to Client:

Individual & Family Data

Current Concerns/Presenting Problems, in order of concern:

1.

2.

3.

What caused you to seek counseling now?

What have you or your child tried that has been helpful?

Have you/your child/your family participated in therapy before? Yes No
If yes, please note dates & providers. Was it helpful?

How will you know if counseling has been helpful?

What are your child's strengths?

Family:

Describe this child's relationships with parents & siblings:

Siblings:

Name	Age	Step-sibling	Shares one parent w/client	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

Others living with family:

Name	Age	Relationship	

Pregnancy & Birth:

1. During this pregnancy, did the mother experience any unusual illness, condition, or accident such as German Measles, RH incompatibility, false labor, etc.? If yes, please describe:

- Yes
- No

2. Was the mother taking any drugs during pregnancy? If yes, please list:

- Yes
- No

3. Was the pregnancy planned?

- Yes
- No

4. Length of pregnancy? _____ Duration of labor? _____ Birth Weight: _____

Were there any problems associated with delivery such as breech birth, Caesarian section, etc.? If so, please describe:

- Yes
- No

5. Were there any feeding problems? If so, please describe:

- Yes
- No

Developmental:

1. At what age did the following occur?:

Walking:		Talking:	
Toilet training:		Dressed & undressed self:	

2. Describe infant's temperament:

3. Did the child have difficulty with strangers or separating from parents? If so, please describe.

- Yes
- No

4 Please list any developmental problems or concerns:

Child symptom checklist

- | | | |
|---|--|--|
| <input type="checkbox"/> Restless, can't sit still | <input type="checkbox"/> Frequent conflicts with teachers | <input type="checkbox"/> Prefers spending time with older children |
| <input type="checkbox"/> Afraid of new situations | <input type="checkbox"/> Immature | <input type="checkbox"/> Often bored in school |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Often teases others |
| <input type="checkbox"/> Often angry and argumentative | <input type="checkbox"/> Uses or has experimented with alcohol or drugs | <input type="checkbox"/> Spends much of free time playing video games |
| <input type="checkbox"/> Does not like to be touched | <input type="checkbox"/> Sleepy and fatigued on regular basis | <input type="checkbox"/> Interrupts, blurts things out |
| <input type="checkbox"/> Sees or hears things that others do not | <input type="checkbox"/> Problems with eating (circle: poor appetite, restricts, overeats) | <input type="checkbox"/> Disorganized |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Over-exercises | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Perfectionist | <input type="checkbox"/> Poor body image | _____ |
| <input type="checkbox"/> Frequent and dramatic mood shifts | <input type="checkbox"/> Does not get invited over friends' houses | <input type="checkbox"/> Avoids going to school |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fails to finish tasks or homework assignments | <input type="checkbox"/> Truant |
| <input type="checkbox"/> Worries | <input type="checkbox"/> Talks excessively | <input type="checkbox"/> Prefers to be alone, Isolates |
| <input type="checkbox"/> Frequently nervous or anxious | <input type="checkbox"/> Forgetful/often loses things | <input type="checkbox"/> Slow learner/difficulty learning |
| <input type="checkbox"/> Feels has to repeat the same actions (touching, counting, washing) | <input type="checkbox"/> Difficulty with math | <input type="checkbox"/> Nail biting or skin picking |
| <input type="checkbox"/> Intimidates others/bullies | <input type="checkbox"/> Difficulty with reading | <input type="checkbox"/> Frequent nightmares |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Difficulty with spelling | <input type="checkbox"/> Need for high degree of supervision at home over play/chores/schedule |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Sets fires | <input type="checkbox"/> Unhappy |
| <input type="checkbox"/> Loses temper quickly / frequent tantrums | <input type="checkbox"/> Has been in physical fights (last 6 months) | <input type="checkbox"/> Sexual pre-occupation |
| <input type="checkbox"/> Lies | <input type="checkbox"/> Failing in school (subject _____) | <input type="checkbox"/> Whines and complains a lot |
| <input type="checkbox"/> Cruel to animals | <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Repetitive movements (rocking, etc.) |
| <input type="checkbox"/> Has difficulty making friends | <input type="checkbox"/> Steals (items such as _____) | <input type="checkbox"/> Talks of suicide or harming self |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Hypochondriac, always complains of feeling sick | <input type="checkbox"/> Has made a suicide attempt |
| <input type="checkbox"/> Procrastinates | <input type="checkbox"/> Prefers spending time with younger children | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cries often | <input type="checkbox"/> Is often teased or bullied | <input type="checkbox"/> Self-harming behaviors (cuts, scratches self) |
| <input type="checkbox"/> Frequent conflicts with friends | | <input type="checkbox"/> Uncoordinated at physical activities |
| <input type="checkbox"/> Frequent conflicts with siblings | | <input type="checkbox"/> Risk taker |
| <input type="checkbox"/> Frequent conflicts with parents | | <input type="checkbox"/> Swears frequently |
| <input type="checkbox"/> Frequent conflicts with step-parents | | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Tics (movement, speech) | | |

Other concerns: _____

Education History:	
1. Did the child attend nursery school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Kindergarten? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. School currently attending?	Grade:
3. What are his/her usual grades in the following subjects? Which subjects does he/she prefer?	Math:
Science:	Reading/English:
Spelling:	Social Studies/History:
Art:	Music:
4. Grades Failed:	Grades Skipped:
5. Is he/she often absent from school? Please explain. <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Does he/she have an Individual Education Plan and/or is he/she coded? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Daily Behavior:	
1. Does your child have nightmares?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does your child have fears?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does your child sleep well?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does your child eat well?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does he/she tend to play alone or with others?	<input type="checkbox"/> Alone <input type="checkbox"/> With Others
6. Does he/she tend to get along with adults?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Is it difficult to discipline him/her?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Would you describe your child as basically happy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Does your child have difficulty with concentration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. What are his or her favorite activities?	
11. Additional comments on behavior:	
12. Other concerns:	

Health & Developmental History

Primary Care Provider: _____

Date of Last Physical: _____

If your child has not had a physical exam in the past year, we urge you to schedule one.

Coordination of services with your child's primary care provider is recommended in order to ensure quality of care. Do you wish to authorize Counseling Associates to coordinate care with your PCP?

Yes If yes, please complete authorization on the reverse.

No

Today's Date: _____ Age: ____ Height: _____ Weight: _____ M or F
 Form completed by: _____ Self Parent Guardian

Child's current health: Good Fair Poor

Specialists:	Current Medications Rx & Dosages:
Psychiatrist:	
Allergies:	Over the Counter/Herbal:
	Does your child use any type of birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____
Client Health History:	
<input type="checkbox"/> asthma	<input type="checkbox"/> eye problems
<input type="checkbox"/> mental retardation	<input type="checkbox"/> depression
<input type="checkbox"/> emotional problems	<input type="checkbox"/> behavior problems
<input type="checkbox"/> suicide attempts	<input type="checkbox"/> psychiatric hospitalization(s)
<input type="checkbox"/> hearing problems	<input type="checkbox"/> speech problems
<input type="checkbox"/> anxiety	<input type="checkbox"/> ADHD
<input type="checkbox"/> alcohol use	<input type="checkbox"/> drug use
<input type="checkbox"/> psychotic disorder	<input type="checkbox"/>
Accidents, operations, hospitalizations:	<input type="checkbox"/> Significant illnesses:
Other:	
If female: Age at 1 st menses: _____ <input type="checkbox"/> N/A Date of last period: _____ Patterns associated with cycle: _____	
Family Health History: <input type="checkbox"/> Client is adopted, history largely unknown	
<input type="checkbox"/> cancer	<input type="checkbox"/> tuberculosis
<input type="checkbox"/> thyroid problems	<input type="checkbox"/> heart disease
<input type="checkbox"/> ulcer	<input type="checkbox"/> mental retardation
	Who in Family?
<input type="checkbox"/> depression	<input type="checkbox"/> bipolar disorder
<input type="checkbox"/> psychotic disorder	<input type="checkbox"/> anxiety
<input type="checkbox"/> alcoholism	<input type="checkbox"/> drug abuse
<input type="checkbox"/> psychiatric hospitalization(s)	<input type="checkbox"/> suicide attempts
<input type="checkbox"/> completed suicide	<input type="checkbox"/> Other: _____

Counseling Associates of New London, PLLC

Counseling Associates of New London: 35 Newport Road, PO Box 1624 New London, NH 03257 (603) 526-4230
 Counseling Associates of Newport: 44 North Main Street, PO Box 43 Newport, NH, 03773 (603) 863-1672
 Counseling Associates of Claremont: 5 Dunning Street, PO Box 1618 Claremont, NH 03743 (603) 542-4332

Authorization for Release of Confidential Information

I hereby authorize ***Counseling Associates of New London, PLLC, Counseling Associates of Newport, & Counseling Associates of Claremont*** to:

EXCHANGE individually identifiable information from the records of the person named below (which may include information concerning treatment of mental health, treatment for drug and/or alcohol abuse, and/or HIV status). The purpose of this disclosure is to **COORDINATE SERVICES**.

Name: _____ DOB: _____

Name & Address of **Primary Care Provider & Practice** with whom information may be exchanged:

Primary Care Provider Name:	
Practice:	
Address:	
Telephone #:	

<input checked="" type="checkbox"/> Please check one: <input type="checkbox"/> The information to be released is limited to only that which is necessary to carry out the purpose of disclosure. <input type="checkbox"/> I specify that only the following information is to be disclosed:	
<input checked="" type="checkbox"/> Please check one: Specify time period from which information is to be released: <input type="checkbox"/> _____ to _____ Or <input type="checkbox"/> All dates of service.	<input checked="" type="checkbox"/> Please check all those that apply: Specify how information may be disclosed: <input type="checkbox"/> copies <input type="checkbox"/> verbal <input type="checkbox"/> fax
<input checked="" type="checkbox"/> Please check one: <input type="checkbox"/> This authorization expires in one year unless otherwise noted. <input type="checkbox"/> Specified expiration date: _____	

- I understand that I need not consent to the release of information specified above in order to obtain treatment services or have services reimbursed.
- I understand that I may revoke this consent at any time by notifying Counseling Associates of New London, PLLC in writing at P.O. Box 1624, New London, NH 03257, except to the extent it has already been relied upon.
- I understand that there is the potential for this protected health information to be redisclosed by the recipient. If the recipient is not a covered entity (e.g. insurance company, health care provider), the disclosed information may no longer be protected by federal & state privacy regulations.

X _____
 Signature of Client / Parent / Legal Guardian

X _____
 Date

 Printed name of Personal Representative

 Legal Authority of Personal Representative

 Witness

 Date



Consent to Treatment

- I acknowledge that I have received, have read (or have had read to me), and understand the **Information for Clients** brochure and the information about the therapy I am considering for myself or my child. I have had all my questions answered fully and to my satisfaction.
- I acknowledge that I have received, have read (or have had read to me), and understand the **Policy Regarding Missed Sessions**. I have had all my questions answered fully and to my satisfaction.
- I acknowledge that I have received, have read (or have had read to me), and understand the **Notification of Privacy Policies Regarding Protected Health Information**. All questions I have regarding this information have been answered to my satisfaction.
- I acknowledge that I have received, have read (or have had read to me), and understand the State of New Hampshire **Mental Health Bill of Rights**. All questions I have regarding this information have been answered to my satisfaction.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist and that, as with any treatment, there are some risks as well as many benefits with therapy. I am aware that I may stop my treatment with this therapist at any time. I understand that I will still be responsible for paying for the services I have already received. I understand that there may be consequences to such a decision outside of my therapist's control (e.g. if my treatment has been court-ordered, I will have to respond to the court).

My signature below indicates that I agree to abide by the terms outlined throughout my professional relationship with Counseling Associates of New London, PLLC, Counseling Associates of Newport, & Counseling Associates of Claremont. I consent to receive services from Counseling Associates & I agree to take an active role in my own treatment.

<input checked="" type="checkbox"/>		
	Signature of client (or person acting for client)	Date
	Printed name	Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Therapist

Date

We believe that it is important for clients to attend all sessions scheduled for them. Missed or canceled sessions are counterproductive and increase the time it takes to bring about the changes that you entered counseling to make. We will work hard to honor the times we set aside to meet and ask you to do the same.

To prevent misunderstandings and confusion, we have found it is important to address this issue at the outset of treatment.

Counseling Associates has a standard 24-hour cancellation policy. Please notify your therapist as soon as you know you will be unable to keep an appointment and **at least** 24 hours, preferably 48 hours, in advance of the scheduled time. This will allow other clients to access this time as well as providing us ample time to find an alternative appointment for you.

The policy of this office is to charge for those missed sessions not canceled with 24-hours notice. **Please note: Insurance and managed care companies will not pay for sessions that you miss and it would be fraudulent for us to submit a claim for these.** You will be responsible for these charges and we will bill you directly.

It is always our intent to be fair in arrangements with clients. We hope you understand that we need to be vigilant about this policy to ensure that we can afford to continue serving the needs of the community. We are sorry, but this charge is **not** waived in the case of illness. This charge is only waived in the following cases:

- In the case of poor travel conditions due to weather that result in local school closings, this charge will be waived if you call to inform your therapist prior to your appointment time that you are unable to attend.
- If you are hospitalized unexpectedly, this charge will be waived.
- If there is a death in the family, this charge will also be waived.

I have read and understood the Policy Regarding Missed Sessions and have had all of my questions answered to my satisfaction. I understand that I will be billed for all missed sessions and late cancellations for which I have not given at least 24-hour notice according to the above guidelines. I understand that I am responsible for these charges and that insurance cannot be billed. I agree to pay for these sessions at the rate of:

- For Self-Pay clients: The usual rate paid per session.
- For Insurance clients: The usual & customary rate established by your insurance company. This includes the rate covered by insurance plus any co-pay.
- Other: _____

✓

Client or Parent Signature

Date