

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: _____

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:

Child Symptom Checklist

- Restless, can't sit still
- Afraid of new situations
- Impulsive
- Often angry and argumentative
- Does not like to be touched
- Sees or hears things that others do not
- Trouble sleeping
- Perfectionist
- Frequent and dramatic mood shifts
- Headaches
- Worries
- Frequently nervous or anxious
- Feels has to repeat the same actions (touching, counting, washing)
- Intimidates others/bullies
- Irritable
- Sad
- Loses temper quickly / frequent tantrums
- Lies
- Cruel to animals
- Has difficulty making friends
- Difficulty concentrating
- Procrastinates
- Cries often
- Frequent conflicts with friends
- Frequent conflicts with siblings
- Frequent conflicts with parents
- Frequent conflicts with step-parents
- Tics (movement, speech)
- Frequent conflicts with teachers
- Immature
- Developmental delays
- Uses or has experimented with alcohol or drugs
- Sleepy and fatigued on regular basis
- Problems with eating (circle: poor appetite, restricts, overeats)
- Over-exercises
- Poor body image
- Does not get invited over friends' houses
- Fails to finish tasks or homework assignments
- Talks excessively
- Forgetful/often loses things
- Difficulty with math
- Difficulty with reading
- Difficulty with spelling
- Sets fires
- Has been in physical fights (last 6 months)
- Failing in school (subject _____)
- Easily frustrated
- Steals (items such as _____)
- Hypochondriac, always complains of feeling sick
- Prefers spending time with younger children
- Is often teased or bullied
- Prefers spending time with older children
- Often bored in school
- Often teases others
- Spends much of free time playing video games
- Interrupts, blurts things out
- Disorganized
- Learning disability

- Avoids going to school
- Truant
- Prefers to be alone, Isolates
- Slow learner/difficulty learning
- Nail biting or skin picking
- Frequent nightmares
- Need for high degree of supervision at home over play/chores/schedule
- Unhappy
- Sexual pre-occupation
- Whines and complains a lot
- Repetitive movements (rocking, etc.)
- Talks of suicide or harming self
- Has made a suicide attempt
- Speech problems
- Self-harming behaviors (cuts, scratches self)
- Uncoordinated at physical activities
- Risk taker
- Swears frequently
- Bedwetting

Other concerns: _____

Updated 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: _____
Updated 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: _____	

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: _____

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Client or Parent Signature

Date