FHL Center for Healing

CHILD/ADOLESCENT REGISTRATION FORM

Child/Adolescent Name:_____ Preferred Name:_____

Gender: M or F DOB: _____ SSN:_____

Address: _____

Street City State Zip

Parent(s) name_____

Hm #: _____ Cell #: _____ Work #: _____

EMAIL _____

Emergency Contact:_____Phone #:_____

Primary Care Physician:_____Phone #: _____

Address:_____

How did you hear about our office? _____

CLIENTS GUARANTOR (Person responsible for Account/Insurance)

Guarantor Name:_____ DOB: _____

Address: _____

Street City State Zip

Home #: _____ Cell #: _____ Work # : _____

Relationship to patient_____ Employer:_____

CHILD'S LIVING SITUATION:

Mother and Father in Same Home Father only Adoptive Parents Mother only

Mother's Name:_____Age:____
Occupation:_____

Father's Name:_____Age:____
Occupation:_____

Guardian's Marital Status: Married____ Divorced___ Separated____ Other____
Please explain:_____

Legal Custody of the Child: Mother____ Father____ Joint____ Other_____
Please explain:_____

If remarried: Name of Step-Parent(s):_____

List all siblings along with their ages: _____

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DEVELOPMENTAL HISTORY

Was the pregnancy with this child: Planned_____ Unplanned_____Child's birth weight:_____

Were there any difficulties in pregnancy/delivery? Yes No _____

Were there any health problems after birth? Yes No _____

Were the family relationships under stress during the pregnancy? Yes No _____

_____

Please circle any symptoms that may have applied to the child during the first year of life (if known):

Crying excessively *Irritability* *Unhappiness*

Sleeping Problems *Eating Problems*

Circle any symptoms that may have applied to the child during the Toddler/Preschool yrs (1-5 yrs old):

Irritability *Jealousy* *Destructive* *Stuttering* *Overactive* *Head Banging* *Temper Tantums*

Bed wetting after 3 *Breath Holding* *Soiling after 3* *Difficult w/transitions* *Chewing clothes*

Ate unusual items *Eating Problems* *Nail Biting* *Withdrawn* *Compulsive actions* *Hesitant*

*Other:*_____

Circle any symptoms that may have applied to the child during Kindergarten-3rd Grade (5-9 yrs old):

Trouble Following Direction *Social Issues* *Aggressive* *Fearful* *Clumsy* *Eating Problems*

Doesn't attempt what he/she could when appropriate *Lack of remorse* *Lying* *Stealing* *Overactive*

*Other:*_____

SCHOOL INFORMATION

Current grade in School: _____ School Name_____

Phone #: _____ Average Grades: A B C D F

Contact Person (teacher or school counselor):_____

Teacher/Counselor's comments about your child:

_____

Has the child ever been held back a grade? Yes No If so, which grade_____

Circle any identified learning problems: ADD ADHD Reading Math Other
please explain:_____

Does your child currently have a learning plan at his/her school: IEP / 504 (Circle which apply)

Results of any testing (other than ISTEP) done by the school:_____

Any Behavioral problems at school: _____

Please list all schools your child has attended from kindergarten to present:

_____

PERSONALITY

Circle any of the following words that best describe your child:

Active *Withdrawn* *Excitable* *Leader* *Likeable* *Reckless*
Ambitious *Submissive* *Sympathetic* *Lonely* *Violent*
Aggressive *Self-Confident* *Often Afraid* *Easy Going* *Impatient*
Bossy *Hard Working* *Impulsive* *Imaginative* *Introvert*
Sick Often *Depressed* *Nervous* *Self-Conscious* *Moody* *Calm*
Extrovert *Serious* *Worrier* *Persistent* *Often Sad* *Serious* *Shy*
Hyper *Caring* *Controlling* *Compulsive* *Sensitive* *Perspective* *Unremorseful*
*Other:*_____

SOCIAL FUNCTIONING

What do your child's friends say about him/her?

_____

How many close friends does he/she have? 0 1 2 3 4 5+

Do friends come to visit at your house? Yes No

Please describe any recent changes in socialization/friends or loss of friends:

_____

Do you have any dating concerns (if applicable)? Yes No Please explain:

_____

Describe any school activities/sports/extracurriculars your child participates in:

_____

Is religion an important part of your child's life? Yes No Undecided

Church attended:_____

PHYSICAL HEALTH

Please rate your child's physical health: Very good Good Average Declining Poor

List any severe illness, injuries and/or hospitalizations, including dates of treatment:

_____
_____
_____

List any medications & dosages, including over the counter and herbal supplements the child takes:

_____
_____
_____

MENTAL/EMOTIONAL HEALTH

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Please explain what problem/s prompted you to seek help for your child, including when the problems started:

_____

_____

Has your child been involved with therapy or seen a counselor before: Yes / No

If you answered yes to the above, please explain: Date/How Long, Issues, Outpatient/Inpatient, Name of Counselor, Phone Number (if known) _____

_____

Do you have concerns about your child in any of the following areas?

Eating Disorder *Yes* *No* *Physical, Sexual or Emotional Abuse* *Yes* *No*

Suicidal Thoughts/Attempts *Yes* *No* *Self Mutilation/Cutting* *Yes* *No*

If you answered Yes to any of the above, please explain:

_____

_____

LEGAL CONCERNS

Has your child ever been arrested or are there pending legal matters? Yes No

If yes, please explain:_____

Is your child on probation? Yes No

If yes, Probation officer: _____Phone # :_____

ALCOHOL/DRUG USE

Please describe any present or past history of drug or alcohol use or concerns:

_____

Has there ever been a family member with a drug/alcohol related problem? Yes No

If yes, please explain:_____

GENERAL INFORMATION

What are the main difficulties that are being experienced at school (if any)?

_____

_____

What are the main difficulties that are being experienced at home (if any)?

_____

_____

What behaviors would you like to see changed in your child?

_____

_____

Feel free to add any additional information below that might be helpful. All information is confidential and used only to benefit your child's therapy.

_____

_____

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Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Patient Name _____ Patient Social Security # _____

Signature of Legal Guardian/Legal Representative _____ Date _____

Relationship to Patient _____ Benefit Plan Subscriber Name _____

Mental Health Benefit Plan _____

RIGHTS AND RESPONSIBILITIES

Experience has shown that when the contract terms of the psychotherapy relationship or evaluation process are clear and explicit from the beginning, some common misunderstandings are avoided. Please read carefully and sign at the bottom.

1. Since you are an integral part of your evaluation and therapy, you have the right to ask questions at any point. You may refuse to participate in any evaluation task; however, an accurate evaluation is better achieved with your cooperation.

2. Questions concerning your therapist's qualifications and experience will always be answered. As well, you may refuse to participate in any intervention, strategy, or behavior suggested by your therapist.

3. Therapy is an interactive, reciprocal experience. The therapist will always attempt to meet the client where they are emotionally. Your cooperation in the relationship is central to the success of therapy.

4. Within certain legal and ethical limits, information revealed by assessment or treatment will be kept strictly confidential and will not be disclosed to another person or agency without your written permission. The limits to this policy are as follows:

    a. If a court of law issues a subpoena, we are required to provide the information required by the subpoena.

    b. If a court of law has ordered you to participate in therapy or to be evaluated by our staff, the results of the treatment or assessment must be revealed to the court.

    c. If you threaten physical injury or death to yourself or another person, we must take steps necessary to protect you or other involved individuals. (This includes disclosure to appropriate authorities or relevant individuals.)

    d. If you or your child discloses emotional/physical/sexual abuse of a minor, we are required by law to report this to the Department of Child Services.

    e. If you were sent here to be evaluated for an attorney, insurance agency, Social Security, or your employer, disclosure is required.

5. You have the right to be informed about policies regarding fees and services.

    a. Co-payment or deductible will be due at the time of service.

    b. Fees are based on the type and length of therapy you receive. You will also be responsible for charges incurred on your behalf with other professionals/agencies; court appearances; test scoring, interpretation or preparation.

    c. We reserve the right to terminate treatment for non-payment of fees and services provided.

    d. Any check that is returned for Non-Sufficient Funds (NSF) will be charged an additional $25.00 above the amount of the check.

    e. Unpaid accounts greater than one session will result in dismissal from the practice until payment is received.

6. You have the right to terminate therapy at any time.

7. If you cancel or do not show for a scheduled appointment and we do not hear from you for 30 days, then it will be assumed you are no longer under our care.

8. There will be an additional charge for processing forms other than medical insurance (i.e. court reports, reports for outside persons/agency).

9. It is your responsibility to become familiar with your own mental health benefits prior to entering into treatment with your therapist. Our staff may be able to provide you with some insurance information, but due to the various plans with each carrier and their confidentiality policies, we cannot guarantee the accuracy of information we receive from your carrier.

10. **APPOINTMENTS:** Your appointment time is set aside just for you. We look forward to meeting you at your reserved time. If you miss an appointment without notice, this means that another person is not able to use that appointment time. If you have an objection to being reminded of your appointment via text message please let your therapist know.

Unless there are circumstances your therapist and you would define as an emergency, it is our policy to charge a fee when it is not cancelled 24 hours in advance. Repeated “no-show” appointments could result in referring you back to the insurance company for reassignment to another practitioner. Your insurance company cannot be billed for fees associated with missed or canceled appointments. The fee for a missed appointment is $100.

I have read and understand my rights and responsibilities:

_____ _____

Child/Adolescent Name Child’s Signature (if age 14 or above) Date

_____ _____

Signature of Parent or Guardian Date