Patient Introduction Forms
(Child)

Your cooperation in completing this form will be helpful in planning services for your child. Please answer each item carefully and completely. All information on this form is confidential and will not be released without your prior written approval.

Child's Full Name:_____Birth Date: ____/____/____Age____Sex____

Home Address:_____
(Street) (City) (State) (ZIP)

Home Phone #:_____Work Phone #:_____

Child's School:_____
(Name) (Address)

School Phone#:_____Present Grade:_____

Teacher's Name:_____

May I contact your child's teacher in order to consult?(Circle one): YES NO

If yes, please sign and date:_____Date:_____

Whom the child is presently living with (Place a check in the appropriate bracket):

	Column A Adult with whom child is living:	**Column B** Non-residential adults involved with child:
Biological (Natural) Mother	( ) _____	( ) _____
Biological (Natural) Father	( ) _____	( ) _____
Stepmother	( ) _____	( ) _____
Stepfather	( ) _____	( ) _____
Other (Specify)	_____ _____	_____ _____

If divorced, who has physical custody of the child (percent?)_____

Does the non-custodial parent have legal rights regarding determining treatment? (Circle one): YES NO N/A

Place the number 1 or 2 next to each check in Column A and provide the following information about each person:

1. Name_____Occupation:_____
(Last) (First)

   Address:_____
(Street) (City) (ZIP)

   Birth Date:_____Drivers Lic.#:_____SS#:_____

2. Name_____Occupation:_____
(Last) (First)

   Address:_____
(Street) (City) (ZIP)

   Birth Date:_____Drivers Lic.#:_____SS#:_____

Briefly describe your reasons for seeking help:_____

_____

_____

Has your child ever received any outpatient or inpatient psychological assistance (Counseling, Therapy, Psychological testing, impatient hospitalization, etc.) in the past? Yes_____ No_____

If yes, describe the type of assistance:_____

Reason for seeking assistance:_____

_____

Duration of Treatment:_____

_____

Name(s) of person who provided treatment:_____

Describe any major changes in your child's life in the past two years:_____

_____

_____

Please circle any of the following areas in which your child is having difficulty:

School	Depression	Anxious	Shyness	Sexual Problems
Parent Divorce	Boredom	Suicidal Thoughts	Drug Use	Alcohol Use
Stress	Friends	Anger	Self-control	Unhappiness
Sleep	Headaches	Social Skills	Memory	Assertiveness
Energy	Loneliness	Self-esteem	Concentration	Education
Nightmares	Eating Problems	Perfectionism	Digestive Problems	Hyperactivity
Irritability	Mood Swings	Attention Problems	Others_____	

List all medication your child is now taking (prescription and non-prescription):

Medication	Dosage (amount & times per day)	Reason
1._____		
2._____		
3._____		

Name of Physician:_____

Address:_____

Phone:_____Fax:_____

Date of last visit:_____Reason for Visit:_____

List any health problems:_____

_____

May I contact your child's doctor in order to consult?(Circle one): YES NO

If yes, please sign and date:_____Date_____
(Signature)

List the people currently living in your home:

Name	Age	Relationship	Occupation

In case of emergency notify (other than parent):

Name:_____Relationship:_____

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

Daytime Phone:_____Evening Phone:_____

Who may I thank for this referral?:_____

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INFORMED CONSENT FOR TREATMENT

PLEASE READ CAREFULLY AND INITIAL THE FOLLOWING:

CONFIDENTIALITY

_____ Your communications with a therapist are confidential. The information you share in therapy will not be communicated to others without your consent except where disclosure is required by law. Disclosure may be required in the following circumstances: (1) Reasonable suspicion of child or elder abuse; (2) Where there is a reasonable suspicion that the patient presents a danger of violence to others; or (3) where the patient is likely to harm him/ herself unless protective measures are taken. In such instances, the confidentiality does not prevail since for the therapist to do nothing would endanger the patient's life and/ or the welfare of another. Disclosure may also be required pursuant to a legal proceeding.

_____ In the event the therapist has an individual contact with a client (where more than one patient has already been seen together) and information is told to the therapist that materially affects the therapy, this information may need to be shared.

CONSENT FOR TREATMENT

_____ I consent to the therapy which my therapist deems advisable or necessary in the treatment of my case. I understand the treatment planning and procedures are agreed upon mutually between the therapist and myself.

FINANCIAL AGREEMENT

_____ I understand that the fee for service is per each 50 minute hour, and I agree to this fee and assume the responsibility for full payment. I understand that the fee structure will be reviewed once a year at which time fees may be increased; however, not more than $10.00 over the current fee and that I will be notified at least one month in advance. If this fee creates a financial hardship, I am free to discuss it with my therapist.

_____ I understand that payment is expected at the time of service. Please have payment ready at the beginning of the hour. Thank you!

_____ In the case that a check is returned because of insufficient funds, a **$25.00** processing fee will be charged.

_____ I understand that cancellation **must be 48 hours** prior to the ***beginning*** of the scheduled session or the full fee will be charged. The scheduling of an appointment does involve the reservation of time specifically for the client.

_____ In the event litigation becomes necessary for the collection of fees owed, I agree to pay such costs in addition to the fees owed, including, but not limited to, the reasonable fees of an attorney.

_____ The therapist will provide a generic form that the patient can use to bill his/her insurance company for direct reimbursement. This form will be provided as often (weekly, monthly, etc.) as the client wishes.

I HAVE READ AND AGREE TO THE ABOVE POLICIES.

Signature_____Date_____