Gabrielle Carey, Ph.D., LMFT DATE:_____

CHILD/ADOLESCENT
INDIVIDUAL FORM

CHILD/ADOLESCENT INFORMATION

Name_____

Address_____ City:_____Zip_____

Home Phone_____ Cell/Pager_____E-Mail_____

Child/Adolescent's BirthDate_____ Age_____ Sex_____ SS#_____

INSURANCE INFORMATION

Name of Parent or Guardian on Insurance Policy:_____

Ins. SSN or Policy #:_____ Date of Birth:_____ Age:_____

Employed by:_____ Phone #:_____

Who referred you to us?_____

PARENT OR GUARDIAN LIVING WITH CHILD/ADOLESCENT

Name_____

Occupation_____ Employer_____

W. Phone_____Cell/Pager_____E-Mail_____

Date of Birth_____ Age_____ SS#_____

Partner/Parent_____

Occupation_____ Employer_____

W. Phone_____Cell/Pager_____E-Mail_____

Date of Birth_____ Age_____ SS#_____

SIBLINGS

Siblings	Age	Sex	Birthdate	SSN	Living at Home Yes	No

ADDITIONAL FAMILY INFORMATION

Is there any other person living in your household other than parents or siblings? Yes____ No____
If yes, please give each person's name and relationship to the child/adolescent.

Are biological parents divorced or separated? Yes____ No____ If yes, for how long?_____
Please provide name, address and telephone number of biological parent not in household.

BASIC HEALTH AND COUNSELING HISTORY

Good____ Fair____ Poor____ Date of last Physical Exam?_____

Name of Physician?_____ Phone_____

Is child/adolescent taking any prescription medication, over-the-counter medications, allergy medications, herbs, etc.? Yes_____ No_____ If yes,what? _____

_____

_____

Has child/adolescent ever been hospitalized? Yes_____ No_____ If so, for what?_____

_____

Were there any significant prenatal or perinatal events? Yes_____ No_____ If yes, what?_____

_____

Any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes____ No____ If yes, what_____

_____

Has child/adolscent ever had counseling in the past? Yes_____ No_____

If so, From_____To_____ With whom?_____

For what?_____

Does the child have any problems socially?_____

Intellectually?_____ Academically?_____

Child/Adolescent's current grade level? Pk4 K 1 2 3 4 5 6 7 8 9 10 11 12

CHEMICAL DEPENDENCY SCREENING

Does the child/adolescent use any of the following substances now or in the past?

Caffeine? Yes_____ No_____ If yes, type and amount? _____

Cigarettes? Yes_____ No_____ If yes, type and amount? _____

Alcohol? Yes_____ No_____ If yes, type and amount? _____

Illicit Drugs? Yes_____ No_____ If yes, type and amount?_____

Other substance abuse?_____

Comments? _____

RATE YOUR CHILD/ADOLESCENT'S CURRENT MENTAL STATUS

	G= Good	**F=Fair**	**P=Poor**	**Comments**
1. Memory/Short	G	F	P	
2. Memory/Long	G	F	P	
3. Insight/Judgement	G	F	P	
4. Attention	G	F	P	
5. Concentration	G	F	P	
6. Affect/Mood	G	F	P	
7. Eye Contact	G	F	P	
8. Body Movement	G	F	P	
9. Speech	G	F	P	
10. Impulse Control	G	F	P	

CURRENT REASONS FOR SEEKING COUNSELING

Briefly describe the problem for which you wish your child/adolescent to have counseling?

What would you like to see happen as a result of counseling?

POLICY

A counseling session is normally 45-50 minutes. It is customary to pay your therapist after each session. A 24-hour cancellation OR rescheduling notice is required; otherwise the usual **full fee** will charged. Emergencies will be handled on a case to case basis.

The therapist will maintain strict confidentiality. However, I understand that suicidal threats, homicidal threats, and child elder abuse will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

I have signed the release of information form for my Insuarance company (if applicable) and I have been given the information form regarding privacy and confidentiality as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I understand that I have the right to refuse treatment at any time.

Parent Signature_____

Adolescent Signature_____

Psychotherapist Signature_____