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Client Information

Form completed by: ( ) Parent ( ) Foster parent ( ) Guardian ( ) Other_____

Are you a single parent? ( ) yes ( ) no

Child's Name:_____ DOB:_____ Age:_____

Gender: ( ) Male ( ) Female Grade: _____ Name of School_____

Address:_____ City:_____ Zip Code:_____

Telephone: H_____ W_____ Cell_____

Parent's email:_____

Therapist may leave a message at : ( ) Home ( ) Work ( ) Cell ( ) Email

Race/Ethnicity:_____

Emergency Contact person:_____

Relationship: _____ Phone#:_____

Consent for Child Treatment

I am the parent/legal guardian of _____with full legal authority to consent to treatment. I give permission for Kristine Hardey, MFT, to provide treatment for this child which may include assessment, advocacy, referral and mental health counseling.

Signature: _____ Date: _____

Relationship to child:_____

Child's main problem/reason for seeking help at this time:_____
_____
_____

How long has your child had these problem, symptoms or issues?_____
_____
_____
_____
_____
_____

Any current stressors that I should be aware of?_____
_____
_____
_____

Has your child now or in the past experienced any of the following?

{ } Suicidal Thoughts
{ } Suicide Attempts or a Plan to harm yourself
{ } Substance Abuse/Dependence
{ } Addiction
{ } Recovery Treatment for addiction such as alcohol, drugs, pornography
{ } Depression (sad, down, affecting biological functioning)
{ } High or low energy level
{ } Angry/Irritable
{ } Loss of interest in activities
{ } Difficulty enjoying things
{ } Crying spells
{ } Decreased motivation
{ } Panic Attacks
{ } Shortness of Breath
{ } Trouble sleeping
{ } Withdrawing from others
{ } Negative thinking
{ } Change in weight or eating habits
{ } Mood swings
{ } Self Harm (Cutting)
{ } Thoughts or Plan to harm others
{ } Poor concentration/Difficulty focusing
{ } Feelings of Hopelessness/Worthlessness
{ } Feelings of shame or guilt
{ } Racing Thoughts
{ } Flashbacks/ Nightmares
{ } Sexual Abuse
{ } Anxious, Nervous or Tense
{ } Low Self Esteem
{ } Hearing Voices
{ } Paranoid Thoughts

{ } Perfectionism
{ } Rituals of counting things, or needing things in a certain order
{ } Issues with body image
{ } Eating disorder
{ } Binge eating/ purging
{ } Feeling a loss of control over eating
{ } Job problems
{ } Adoption
{ } Other

Describe any behavioral or emotional problems your child is having:_____
_____
_____
_____
_____

Describe the impact of your child's issues on the family:_____
_____
_____
_____

Describe your child's strengths and unique qualities:_____
_____
_____
_____

Previous Treatment:

Has your child been in therapy before? Y N

What did you like/dislike about your previous treatment?_____
_____
_____

Has your child had any hospital stays for psychological concerns: Y N

Date: Reason for stay:

Has your child now or in the past had thoughts of harming themselves or harming someone else? ( ) yes ( ) no

If yes, what steps were taken to ensure safety?_____

Developmental History:

Did your child walk, talk and read at appropriate developmental milestones?

Any learning delays, trouble in school?_____

During pregnancy, did mother:

( ) drink ( ) drugs ( ) illness ( ) accident

( ) problems with pregnancy ( ) have prenatal care ( ) problems in labor or delivery

If yes, please describe:_____

Medical History:

Primary Care Physician: Name_____ Phone_____

Address:_____

How would you rate your child's current physical health?_____

When was your child's last physical?_____

Any health concerns that are impacting your child's mental health?

_____

Does your child exercise regularly? Y N

List any current or important past medications:

Medication and Dose:	Response to medication:
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Raised by: { } Mother { } Father { } Step-Mother { } Step-Father { } Grandparents { } Other

Describe your child's relationship with family members:

_____

_____

_____

_____

Does this child have siblings? Y N

First names and ages:_____
_____

Describe your child's relationship with them:_____
_____
_____

Any history of neglect? Physical Abuse? Verbal, Emotional, Spiritual Abuse?

Sexual Abuse? Any family history of substance abuse?

Any family history of mental illness (including depression, anxiety}?

Any family history of suicide?

Any history of domestic violence?

Any additional family information?

Social History:

Describe your child's relationship with peers and/or friends?_____
_____
_____
_____

How would you describe your child's social support?_____
_____
_____
_____

Has your child ever been bullied? ( )yes ( )no

Has your child ever bullied others? ( )yes ( )no

Does your child have any hobbies/interests?:

Describe any cultural concerns:

Educational History:

What grade is your child currently in?_____

School:_____

Are there any services or special accommodations being provided for the child?_____
_____

Does your child have and IEP or a 504 plan in place? ( ) yes ( ) no

If yes, please explain_____
_____

Has your child been assessed for a learning delay and if so, what was the diagnosis?_____
_____

Any history of ADHD? Y N

Any additional information that you think would be important to know:

Are there presently any child custody issues involving you or your family?_____
_____
_____

Does your family currently have Child Protective Services involvement? Y N

If yes, why is CPS involved?

Case Workers Name: _____ Phone: _____

Additional Information:

What are your goals for therapy?

What expectations do you have for therapy?

Welcome to my practice. First of all, I want to commend you for taking the first steps toward hope and healing. The therapeutic process can provide such freedom. This document contains important legal and ethical information about my professional services and it is important that you take the time to read and understand it.

The therapeutic relationship is vital to the success of your therapy. Therapy works in part because of the clearly defined rights and responsibilities held by each person. As a client, you have certain rights. There are also legal limitations to those rights that you should be aware of.

Goals of Counseling:

There can be many goals for the counseling relationship. And these goals can change or evolve as therapy moves forward. Some of these goals can be long term such as improving the quality of life, learning to live with mindfulness, recovery, or restored relationships. Others may be more immediate goals such as decreasing anxiety, symptom relief, changing a behavior, or increasing social support. Whatever the goals for therapy, they will be set by the client according to what they want to work on during their sessions. This is your journey and while I am there as a guide and support, it is imperative that you embrace the desire to change and do the work necessary to move towards your goals. I may make suggestions, but ultimately, the goals are yours and the time in therapy is yours.

Risks/Benefits of Counseling:

Counseling is an intensely personal process. If you choose to enter into the journey, it can bring up painful memories, hurtful experiences or even reintroduce certain traumas into your thinking. There are no guarantees that therapy will work for you. Clients can make progress then return to old patterns of behaving. Progress may happen slowly. Counseling requires a very active effort on your part. In order to get the most out of therapy you will need to work on things, do the homework, engage in reflection outside of our sessions.

There are several benefits to therapy. Counseling can help you develop essential life skills, reduce symptoms of mental health issues, improve the quality of your life and relationships, develop healthy styles of relating, communicate more effectively, take better care of yourself, grow in knowledge, have more useful coping skills and develop confidence in who you were meant to be.

Confidentiality:

Trust is at the heart of the therapeutic relationship. For this reason, every effort will be made to keep your personal information private. If you wish to have your information released we will discuss whether that is in your best interests, and you will be required to sign a consent form before such information is released to anyone. Safety is also at the heart of therapy. I have a legal and ethical responsibility to you and the community. Because of this, there are some limitations to confidentiality. I may consult with colleagues on your case to offer you the best possible help. In the even that I speak with another therapist, no identifying information such as your name will be released. Therapists are required by law to release information when the client poses a risk to themselves or others. As well I am a mandated reporter if there are any issues of child or elder abuse. If I am subpoenaed, I may be required by law to release information, but I would consult with other professionals and limit the release to only what is necessary by law. In keeping with the laws surrounding confidentiality, I also wanted to mention that if by chance, we should randomly see one another out in the community, I will not initiate a greeting. If you however were to recognize and greet me, I would respond appropriately, keeping in mind that anything you may want to share should be done in session.

Appointments:

Appointments will be 50-60 minutes. We will decide together how often you would like to be seen. The time scheduled for you is designated for you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hours notice, you will be responsible to pay for your session. I understand that circumstances do arise that are out of your control. If this is the case, you will not be responsible for the fee. In addition, you are responsible for coming to your appointment on time. If you are late, your appointment will still need to end on time.

Fee Schedule:

Appointment Fee	Income
$150	$80,000 plus
$125	$60,000-$80,000
$100	$40,000-$60,000
$75	Less than $40,000
$60	Full-Time College Students and/or Veterans

You are responsible for paying at the time of your session unless prior arrangements have been made. Fees are not negotiable. To receive sliding scale fees, you must present proof of income through recent pay stubs or tax forms. Fees are subject to change at the therapist's discretion.

Confidentiality and Technology:

As your therapist I will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communication will not occur. If you prefer to communicate via email or telephone to arrange things like appointments or updates, please be advised of any friends, family or significant others who may have access to your phone or computer.

Contacting Me:

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. You may leave a message on my confidential voicemail and I will get back to you as soon as possible, but it may take a day or two for non-urgent matters. If you call on a Friday, I will return your call on Monday as I do not work on the weekends. If your call is urgent and you feel you cannot wait for a return call or it is an emergency, please go to your local hospital or call 911.

Client
Signature_____Date_____