CHILD/ADOLESCENT CLIENT HISTORY

Child's Name_____Date of Birth_____Date_____

Person Completing Form_____Relation to Child_____

Primary Care Dr._____Other Dr. Treating Your Child_____

1. The Family-List yourself and all members living in the home including your child.
   Name Sex Age Place of Work or School
   _____
   _____
   _____
   _____
   _____
   _____
2. If there have been any parental separations or divorces, give date(s), name(s) of other parent figures, and list which parent(s) has legal and which has physical custody of your child.
   _____
   _____
   _____
3. Family Members not living with you (for example, grown children).
   _____
   _____
4. At what age did your child: walk_____ say single words_____ fully toilet trained_____
   ride a bicycle_____ write his/her name_____ read 20-30 words_____
5. Were there any difficulties with your child's birth, infancy, or preschool development?
   _____
   _____
   _____
6. List any medical problems which your child currently has_____
   _____
   _____

7. List any medications which your child takes often (include vitamins, birth control pills, and non prescription drugs._____
8. List any surgeries, major injuries, or illnesses your child has had_____

   _____
9. Does your child smoke, drink alcohol, or use other drugs? _____
10. Does your child have trouble with sleep? _____
11. Does your child have any eating or weight gain problems? _____
12. Are there any family members (parents, siblings, grandparents, aunts, or uncles, cousins) who have had emotional, mental health, or substance abuse difficulties? (Include behavior or school problems, seizures/epilepsy) _____

    _____

    _____
13. Has anyone in your family ever seen a counselor or doctor for emotional, mental health, or substance abuse difficulties? If yes, what and when? _____

    _____

    _____
14. Has anyone in your family ever taken any medications for emotional, mental health, or substance abuse difficulties? If yes, who and when? _____

    _____

    _____
15. Has anyone in your family ever been in a hospital for emotional, mental health, or substance abuse difficulties? If yes, where and when? _____

    _____

    _____
16. Has anyone in your family attempted suicide? _____
17. How does your child get along with other his/her age? _____

    _____
18. How does your child get along with others in the family? _____

    _____
19. How does your child do in his/her school work? _____

    _____
20. Has your child been in special education? If yes, when and for what reason? _____

    _____
21. What other things would be helpful to know about your child or your family?

New Directions EAP, Inc.

1575 Marion Ave.

Mansfield, OH 44906

Information Form

Please print legibly and return to receptionist

Patient Full Name _____

Preferred Name _____

Birthdate_____ Age_____ Male_____ Female_____

Residence Street Address_____

City, State, Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Please Mark * for preferred number

Marital Status_____ Spouse's Name_____

Patient's Social Security Number_____

If a minor, parent of guardian's name(s)_____

Patient's Employer (or Parent's employer, if minor)_____

Are you using EAP Services?_____ If so, what employer?_____

Insurance Company_____

(Please give card to receptionist for copying)

Name of Policy Holder_____ Policy Holder Birthdate_____

Policy Holder's Social Security Number _____

Nearest Relative not residing with you _____

Relationship to you _____ Phone _____

In case of emergency, please contact _____

Relationship to you _____ Phone _____

Date _____

New Directions Counseling Center

CONSENT FOR TREATMENT

I further authorize and request that my therapist carry out psychological examinations, treatments, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful it may at times be difficult and uncomfortable.

CONFIDENTIALITY

I understand that all information between myself and my therapist is held strictly confidential, and my therapist will not release any information about my therapy unless permitted by law or:

1. I agree in writing to permit such a release.
2. I present a physical danger to myself,
3. I present a danger to others,
4. Child/elder abuse/neglect is suspected.

I understand that in the latter 2 cases, the therapist is required by law to inform potential victims and legal authorities so that protective measure can be taken.

If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions.

FINANCIAL TERMS/CONSENT TO BILL INSURANCE

Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be billed for me and my Provider will be paid directly by the carrier. I agree to release information to my insurance company for billing as requested. I will be responsible for any applicable deductibles and co-payments. I agree to make these payments at each appointment. I understand that if I am not eligible at the time services are rendered, I am responsible for payment, even if the determination is made after services are rendered. ***Please be advised that failure to give 24 hours notice of cancellation of your scheduled appointment will result in a $35 charge billed directly to you.***

If I am without health plan/insurance coverage, payment arrangements will be made prior to my first visit. Visa and MasterCard accepted.

HIPAA

I have been provided a copy of the Ohio "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information" notice.

I have reviewed and understand the information.

_____ _____

Print Client Name **Date**

_____

Client Signature (or Parent/Guardian signature if minor)