# Cleary Counseling and Consultation, Inc

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Date_____

**CHILD/ADOLESCENT INFORMATION**

Client Name _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Child Cell _____ Child Email _____

School _____ Grade _____ Religious Affiliation _____

**PARENT/GUARDIAN INFORMATION (If applicable)**

Father's Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work # _____ Cell # _____

Email Address _____ Do you text? Yes No

Birth date _____ Social Security # _____

Occupation _____ Place of Employment _____

Education (Highest Grade Completed) _____ Marital Status _____

Religious Affiliation _____

Mother's Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work # _____ Cell # _____

Email Address _____ Do you text? Yes No

Birth date _____ Social Security # _____

Occupation _____ Place of Employment _____

Education (Highest Grade Completed) _____ Marital Status _____

Religious Affiliation _____

**SIBLINGS**

| Name | Birth date/Ages | Grade in School | Living at Home |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Whom should we contact in case of an emergency? _____

Preferred way of confirming appointments: _____Home _____Cell _____ Text _____E-mail

Whom may we thank for referring you to us? _____

May we send a thank-you to the referral source? Yes _____ No _____

1. Briefly describe the problem for which you are seeking help.

_____

_____

_____

2. How do you think we can best assist you?

_____

_____

3. Who is your personal physician/pediatrician? _____

4. When was your last physical examination? _____

5. Please describe any physical disabilities or health problems.

_____

_____

6. Please list any medications you are now taking:

_____

_____

7. Have you or your child received psychiatric help or psychological counseling before? (Circle) YES NO

If yes, with whom and dates? _____

Please check any of the following symptoms/problems that pertain:

- ☐ Fears or phobias
- ☐ Shyness
- ☐ Having to do things over and over
- ☐ Intrusive thoughts
- ☐ Making decisions
- ☐ Need to be in control of everything
- ☐ Nightmares
- ☐ Relaxation
- ☐ Stress
- ☐ Coping with a traumatic event
- ☐ Unresolved grief
- ☐ Depression
- ☐ Unhappiness
- ☐ Inferiority Feelings
- ☐ Suicidal thoughts
- ☐ Lack of ambition
- ☐ Blocked emotions
- ☐ Tiredness
- ☐ "Up-and-down" feelings
- ☐ Lack of Energy
- ☐ Loss/Increased Appetite
- ☐ Sleep problems
- ☐ Concentration
- ☐ Procrastination
- ☐ Memory
- ☐ Relationship problems
- ☐ Loneliness
- ☐ Anger/Temper
- ☐ Frustration
- ☐ Self control
- ☐ Headaches
- ☐ Stomach Problems
- ☐ Bowel Problems
- ☐ Health Problems
- ☐ Weight
- ☐ Sexual Problems
- ☐ Alcohol or drug use
- ☐ Education
- ☐ Work
- ☐ Career choices
- ☐ Parents Separation/Divorce
- ☐ Legal Matters

Parenting Issues

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## CONSENT FOR TREATMENT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I acknowledge that I have received, read, and understand the policies and procedures as described in the Client Information forms and do so indicate by affixing my initials next to each of the following points:

_____ 1) Confidentiality - I am aware that an authorized agent of my insurance carrier or other third party payer may request and be provided with information about the type(s), cost(s), and date(s) of any services or treatments I receive so that payment may be provided to my therapist.

_____ 2) Payment and Billing Policies - I am aware that I am responsible for payment in full for any charges for services provided on my behalf unless they are specific services provided under the benefit plans of my insurance and as designated in any contract between my therapist and my insurance company and its lawful delegates.

_____ 3) Financial Responsibility - I am aware that I may terminate treatment at any time without consequence, but that I will still be responsible for payment of the services I have received. I am aware that if I have not paid for services received, my treatment may be discontinued and my account turned over for collection.

_____ 4) Appointments and Cancellations - I am aware that any cancellations of appointments must be made at least 24 hours in advance of the appointment and if I do not cancel or do not show up I will be charged for that appointment.

_____ 5) Intra-agency Consultation - I am aware that my therapist may consult or share information with other members of the professional staff in the therapeutic office if such consultation can be expected to be helpful in dealing with a problem being discussed in therapy and that those staff may have access to relevant information in my client file. I am also aware that no information about me, or my situation, may be communicated to others outside this therapeutic office without my explicit permission unless such action is required by law.

_____ 6) Risks of Psychotherapy - I am aware that the practice of psychotherapy is not an exact science and that predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by the therapist identified below.

_____ 7) Court Testimony and Custody Evaluations – I am aware that therapists make every effort to maintain client confidentiality and therefore do not testify in court regarding custody, divorce action, or other legal matters. I agree not to contact my therapist personally or via my attorney to testify in court. If my therapist is contacted/subpoenaed on my behalf for testimony, I agree to pay all court costs, legal fees, and hourly rates for my therapist's time.

_____ 8) I do _____ do not _____ have questions about this consent for treatment/financial policy.

I do hereby seek and consent to participate in evaluation and or treatment with the therapist identified below.

_____ _____

Parent or Guardian of Minor Child Date

_____ _____

Therapist Date