Counseling for Growth and Change, L.C.

Registration Information – Minor

Name of Minor: _____ Today's Date: _____

MINOR (CLIENT):

Home Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Soc. Sec. #: _____

Date of Birth: _____ Age: _____ Grade level: _____

School: _____ Favorite Activity: _____

Who does the minor live with? (Biological parent, foster family, other family member?)

_____

PCP Name: _____ Medications: _____

_____

Physical Illnesses: _____ Allergies: _____

BIOLOGICAL/ADOPTIVE PARENTS:

Mother's Name: _____ Social Security #: _____

Home Address (*if different from above*): _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone _____

Date of Birth: _____ Age: _____ Occupation: _____

Employer: _____ Emp. Address: _____

Father's Name: _____ Social Security #: _____

Home Address (*if different from above*): _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone _____

Date of Birth: _____ Age: _____ Occupation: _____

Employer: _____ Emp. Address: _____

BIOLOGICAL/ADOPTIVE SIBLINGS:

Name: _____ Age: _____ DOB: _____ Sex: _____

Name: _____ Age: _____ DOB: _____ Sex: _____

Name: _____ Age: _____ DOB: _____ Sex: _____

Name: _____ Age: _____ DOB: _____ Sex: _____

Name: _____ Age: _____ DOB: _____ Sex: _____

Name: _____ Age: _____ DOB: _____ Sex: _____

(Next page please)

Counseling for Growth and Change, L.C.

PAYMENT INFORMATION

___ I will be personally responsible and privately paying for charges of therapeutic services.
___ I will be paying for therapeutic services with my insurance. (Please complete following information on insurance.).

INSURANCE (a copy of your card is required, please)

Primary Insurance Company Name:	Secondary Insurance Company Name (if any):
_____	_____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Birthdate: _____	Subscriber Birthdate: _____
Subscriber #: _____	Subscriber #: _____
Group #: _____	Group#: _____
Co-payment: $_____	Co-payment: $_____

INSURANCE PAYMENT AUTHORIZATION

I hereby direct my insurer to pay directly to Counseling for Growth & Change, LC., and/or my therapist all benefits due them as a result of claims for my therapeutic services. Although covered by insurance, I am aware that I am personally responsible for all charges. A photo static copy of this authorization will be valid as the original.

Signature of Parent/Legal Guardian: _____ Date: _____

INSURANCE RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize Counseling for Growth & Change, LC., and/or my therapist to release information concerning my present illness to insurance carrier for the purpose of processing my claims. A photo static copy of this authorization will be valid as the original.

Signature of Parent/Legal Guardian: _____ Date: _____

CANCELLATION POLICY

My therapist has reserved time to work with me, so I agree to contact this office 24 hours in advance of any necessary rescheduling or cancellation. Failure to provide such notice will result in a cancellation fee, and I understand I am responsible for payment of that fee.

Signature of Parent/Legal Guardian: _____ Date: _____

(Next page please)

Counseling for Growth and Change, L.C.

Assessment Information - Minor

Minor's Name: _____ Today's Date:_____
Minor's Date of Birth: _____ Age: _____ Grade in School: _____

Who referred you to this office? _____

Please place an "X" by the answer that is closest to describing your situation and/or fill in the blanks where necessary. Thank you.

1. What are your current concerns related to the minor today?

_____
_____
_____

2. What is the quality of your family relationships at this time?

_____
_____

3. Are there school issues that you are concerned about? If so, please describe.

_____
_____

4. Are there drug/alcohol issues related to the minor? If so, what are they?

_____
_____

5. Is your family involved with the Department of Human Services or Juvenile Court? If so, how and why? _____
_____

6. What problem(s) bring(s) the minor to counseling?

_____ Depression
_____ Family
_____ School
_____ Sexual Abuse
_____ Physical Abuse
_____ Divorce/Separation
_____ Anxiety
_____ Adjustment
_____ Grief
_____ Criminal charges
_____ Other issues (please describe in as much detail as possible): _____
_____
_____

(Next page please)

7. Are the minor experiencing any of the following?

_____ Guilt	_____ Poor appetite	_____ Fatigue
_____ Panic/Anxiety	_____ Loss of interest	_____ Irritability
_____ Sexual issues	_____ Trouble concentrating	_____ Worry
_____ Trouble sleeping	_____ Feelings of hopelessness	_____ Aggression
_____ Wetting/Soiling	_____ Tantrum behavior	_____ Poor memory
_____ Touching others inappropriately		_____ Poor boundaries with others

Other significant problems/behaviors, please explain: _____
_____
_____

8. Has the minor participated in counseling before? If so, with whom, and for how long? _____. When? _____
For what issues? _____

9. Have others in the minor's family received counseling services before today? If so, where and when? _____ What other family members were involved in the counseling sessions? _____
_____

10. Is the minor taking any medications currently? _____ Yes _____ No
If yes, what kind (please include name & dose of medication)? _____
_____
_____
Who is prescribes this medication? _____

11. Do anyone in the minor's family have issues with drugs/alcohol? If so, please describe:
_____
_____

12. Is there a family history of mental health issues, drug and alcohol use, domestic violence or criminal activity? If so, please describe: _____
_____
_____

13. Is there anything else about your child and your family that might be helpful to the counseling process? If so, please describe: _____
_____
_____

_____ _____ _____
Parent/Legal Guardian's signature Date Relationship to child