Client Questionnaire

Please fill out this biographical background form as completely as possible. It will help me in your child's treatment. All information is confidential as outlined in the informed consent form.

Name of Child:_____

Date of Birth:_____

Child's Cell Phone #:_____Child's Email:_____

Child lives with: Mother Father Both Parents Guardian

Who has legal custody? Mother Father Both Parents Guardian

Mother's Name:_____ Date of Birth:_____

Address:_____City:_____Zip:_____

Telephone: H: _____W: _____Cell: _____

May I leave a message? If so, on which number? _____

E-mail:_____ May I e-mail you?_____

Father's Name:_____ Date of Birth:_____

Address:_____City:_____Zip:_____

Telephone: H: _____W: _____Cell: _____

May I leave a message? If so, on which number? _____

E-mail:_____ May I e-mail you? _____

Referral Source:

_____

Siblings

(Names/Ages/Grade):_____

_____

_____

Other people living in the child's home:_____

Insurance Carrier: _____Phone Number on Card:_____
Policy ID Number:_____Group Number:_____
Primary Policy Holder's Name:_____Date of Birth:_____

Please indicate if the following symptoms are affecting your child. (Leave blank if not applicable):

Depression Panic Attacks /Frequency _____

Feel Hopeless Rapid heartbeat/palpitations

Think about suicide Constant worry and anxiety

Feel irritable Fear of social gatherings

Cry easily Anger Outbursts

Loneliness Unwanted or distressing thoughts

Feel guilty Thoughts about traumatic events

Feel worthless Phobias, unreasonable fears

Withdrawal from people Nightmares

Unable to have a good time Excessive bedwetting

Lost interest in usual activities Bowel disturbances

Unmotivated to complete daily tasks Headaches

Decreased energy/fatigue Chronic Pain

Trouble falling asleep Inattentive/distractible

Trouble staying asleep Memory problems

Trouble waking up Hyperactivity

Recent weight gain or loss Racing thoughts

No appetite Hear voices

Binge eating See things that are not there

Intentional vomiting Think about hurting someone

School problems Repetitive behaviors

Peer problems Substance abuse

Does your child have any suicidal feelings? _____ For how long has he/she had them?
_____
Has your child ever attempted suicide? _____ How?
_____
Was your child ever in a psychiatric hospital?
_____
Has your child ever been prescribed psychiatric medication?
_____
Is your child currently taking any prescription medication?
_____
Is there a family history of any of the following?
(Please Check) (Family Member)
Alcohol Abuse: yes no _____
Substance Abuse: yes no _____
Depression: yes no _____
Suicide Attempts: yes no _____
Bipolar Disorder: yes no _____
Schizophrenia: yes no _____
Eating Disorders: yes no _____
Parental Status:
If partnered, for how long: _____ If married, on what date: _____
If separated or divorced, please give the date and on the back of this page explain the circumstances, custody & visitation schedule, and communication status between parents. Additionally, please attach a copy of the custody order.
If a parent is deceased, please give the date and explain the circumstances:

Birth and Toddler History:
Was your child adopted? _____ If yes, at what age?_____
If adopted, please give any relevant information about biological parent history:
Were there any illnesses/complications during pregnancy with this child?_____
Total number of pregnancies: _____
Were there any miscarriages? _____

Please explain the circumstances:

How does this child compare with her/his siblings?

During the infant/toddler years, did either parent stay home full or part time? If so, please elaborate on the circumstances.

At what age did the child go to day care? What type of situation was this (e.g.home, day care center, etc.)? How many hours per week?

Did your child have history of emotional or behavioral difficulties, such as (please circle): head banging, breath holding, day soiling, excessive temper, tantrums, irritability, obsessive thoughts, compulsive need to count things or touch them, overly aggressive behavior, or difficulty controlling his/her impulses?

Approximately when did this start?

School History:

Name of school:_____ Grade :_____
Does your child attend public or private school? _____
Has your child ever been home-schooled? _____
Schools Attended:
Elementary:_____

Junior High:_____

High School: _____

Any skipped grades? _____ What grades? _____

Any repeated grades? _____ What grades? _____

Favorite subjects:_____

Difficult subjects: _____

Does your child have behavior problems at school? _____

Has your child ever been suspended/expelled from school? _____

If so, for what reason?

Has your child attended any gifted and talented classes? _____

If so, please list:

Has your child participated in special education classes? If so, please describe the type of services provided, and in which categories your child was placed:

Medical/Mental Health History:

Has your child had any serious accidents/injuries/illnesses involving such things as (circle):

Convulsions, high fevers, loss of consciousness, fainting, headaches, allergies, chronic fatigue, head injuries, ear problems, meningitis?

Please explain:

Did your child ever require hospitalization?

If so, please explain:

Current Pediatrician's name: _____

Address and Phone Number: _____

When was your child's last complete physical?

Does your child have any health problems at this time?

Has your child previously seen a therapist? If so, at what age? Whom did he/she see? About how many meetings did the child/family have?

Has any member of your child's immediate family participated in mental health treatment? If so, please explain:

Has your child ever been molested? If so, when and by whom?

About Your Child:

List any significant life traumas:

List any significant life influences:

How would you characterize your child's relationship with his/her siblings?

In your family, with whom does your child share secrets, worries, feelings?

What discipline methods have you found to be most effective with your child?

What are your child's favorite activities?

Does your child participate in any after-school activities?

Please list any chores or jobs your child has at home (e.g., babysitting, making her/his bed, taking out the garbage, etc). How well does your child carry out the above chores?

What are your main concerns about your child?

Name of Parent/Guardian_____

Date _____

Informed Consent for Treatment of a Minor

Name of Client: _____Date of Birth:_____

I, _____, as the parent of the (Name of parent/guardian) above child, authorize and consent for my son/daughter to receive treatment and counseling services provided by Jill Silverman, L.C.S.W.

Parents have the legal right to be appraised of the details of their minor (under the age of 18) child's treatment. Parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. However, treatment with a minor often progresses best with a good-faith agreement to confidentiality between the parents and their child so that the child can be assured of his or her confidentiality in therapy sessions. Consequently, I may discuss the treatment progress of a minor client with the parent or caretaker, but preferably not details that would decrease trust between the minor and me. Minor clients and their parents are urged to discuss any questions or concerns that they have on this topic.

_____

Signature of Parent/Guardian Date

_____

Address City Zip

_____

Home Phone Work Phone Cell Phone

_____

Signature of Therapist Date

Appointments: A scheduled full session consists of a 50 minute time period. Clients are generally seen either weekly or more or less frequently depending on need. I have a telephone voice mail that is available at all times for routine messages. I collect my messages frequently and will make every attempt to return calls within 24 hours. If it is after hours or the weekend and you are experiencing a mental health emergency (thoughts of harming yourself or someone else) and are unable to reach me, call 911 or go to your nearest emergency room for assistance. You may call the San Diego Crisis Hotline at (800) 479-3339 or (619) 557-0500. Trained counselors are available 24 hours, 7 days a week.

Payment and Fees: Payment is due at the time of the appointment unless other arrangements have been made or if you are using insurance. Clients are responsible for copayments, co-insurance, and deductibles. Except where there is a clear emergency, sessions missed or cancelled with less than 24 hours notice will be charged for the full session. Insurance companies do not pay for missed appointments. I accept MasterCard, Visa, Discovery, American Express cards. Fees are discussed prior to the first appointment. All financial and personal information is kept in a secure, locked file. If you have insurance which provides coverage for out of network mental health treatment, please let me know as some insurance plans reimburse a portion of the fee.

Confidentiality: Contents of all therapy sessions are confidential and generally no information about your child will be released without your consent. If it is necessary to speak with other mental health providers, physicians, school professionals, or family members, I will ask you to sign a release of information form so that I may communicate with them.

There are noted exceptions to confidentiality. I am required by law to report suspected child or elder abuse and take action when a client is a danger to self or others or gravely disabled. In cases in which a client implies a plan for suicide, I am required to report to authorities and make reasonable attempts to notify the client's family. Additionally, when a client discloses intentions of a serious threat of violence against another person, I am required to warn the intended victim and contact legal authorities. Insurance companies and other third-party payers are given information that they request regarding claims for therapy services. Information that may be requested includes dates of service, diagnosis, treatment plans, progress in therapy and case notes. Confidentiality is also subject to waiver when disclosure is court ordered or if there is litigation that calls into question your mental health.

Consent for Treatment: By signing below, I am indicating that I have read the above information and consent for my child to participate in treatment. I agree that I have been informed of the fee schedule, late cancellation policy, and the limits of confidentiality.

_____

Client Name (Please Print)

_____

Signature of Parent/Guardian Date

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your health information privacy:
As part of providing professional care, I am committed to maintaining the privacy of your personal health information. I am also required by law to keep your information private. HIPPA (The Health Insurance Portability and Accountability Act) requires that I provide you with this notice of privacy practices.

I will use information about your health mainly to provide you with treatment, to arrange payment for our services, to file claims with insurance companies, and for some other business activities that are legally referred to as "health care operations."

If it will be useful to disclose or release your information for any other purposes, I will ask you to sign an authorization form for release of information.

Your health information is confidential. However, there are instances when the law requires me to share it. For example:

- If there is a serious threat to your health and safety or the health and safety of another individual or the public. I only share information with the person or organization that is able to help to prevent or reduce the threat.
- If there is any suspicion of child abuse, neglect, molestation, or sexual abuse.
- If there is any suspicion of elder abuse or neglect.
- If you are unable to take care of basic needs for yourself.
- If disclosure of your health information is court ordered.

Your rights regarding your health information:
- You can ask me to communicate with you about your health and related issues in a way that is more private for you. For example, you can ask me to call you at work and not at home, or ask me not to leave a telephone message on a home answering machine.
- You have the right to ask me to limit what I tell people who are either involved in your care or the payment for your care, such as family members and friends. I will keep our agreement except if it is against the law, in an emergency, or when the information is necessary to treat you.
- You have the right to look at the health information I have about you, such as your treatment and billing records. Please contact me to arrange how to see your records.
- If you believe certain information in your record is incorrect or missing, you can ask meto make some kinds of changes to your health information. You must make this request in writing and tell me the reasons you want to make the changes.
- You have a right to copy of this notice. If I change this notice, I will post the new version on my website or you can obtain a new copy from me.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can contact the United States Secretary of Health and Human Services at:

The Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Room 515F, HHH Bldg.
Washington D.C., 20201.

Filing a complaint will not change the health care I provide you in any way.
If you have any questions regarding this notice or your health information privacy, please discuss them with me. My contact information is:

Bill Martin MFT
1337 Camino Del Mar, Suite E
Del Mar, California, CA 92014
858.755.2407
billm@counseling-connection.com

Client Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices of Julie Morrell MFT., effective July 5, 2011.

_____
Print Name of Client or Responsible Party (if client is under the age of 18)

_____
Signature of Client or Responsible Party

_____
Date