Client Information Form for Child <18 Years

Today's Date: ____/____/____

Basic Information:

1. Child's legal name:_____ Date of Birth:_____

Child's preferred name: _____

Child's gender: ____ M ____ F ____ Other (describe):_____

Name of person(s) completing this form:_____

Relationship to child:_____

2. Parent/guardian name: _____

Address:_____

Preferred phone:_____ Email:_____

3. Parent/guardian name:_____

Address:_____

Preferred phone:_____ Email:_____

4. Are parents married? ____ Yes ____ No Living together? ____ Yes ____ No If no to either/both, please explain:_____

5. If divorced, please explain custody arrangement:_____

_____

6. If divorced and only one of you is accompanying the child, do you have sole or joint custody?

____ Sole ____ Joint

7. Pediatrician's name:_____ Phone:_____

Address:_____ Date of last visit:_____

8. Any health concerns? ____ No ____ Yes If yes, describe _____

_____

9. Normal birth/developmental milestones? ____ Yes ____ No If no, describe _____

_____

_____

10. Speech, language, or hearing problems? ____ No ____ Yes If yes, describe _____

_____

11. List medications your child takes:_____

_____

Information about your Child's Problem:

1. Please describe the nature of the problem concerning your child:_____

_____

_____

_____

_____

2. Check all the problems or symptoms below that apply to your child:

____ 'Acting out'/disruptive/oppositional behavior at school or home
____ Academic problems
____ Addiction/alcohol use
____ Anxious, fear
____ Difficulty falling or staying asleep, excessive sleeping
____ Difficulty giving or receiving affection
____ Difficulty with attention or concentration
____ Eating disorder: bulimia, anorexia, binge eating
____ Enuresis or encopresis
____ Extreme shyness/social phobia/social isolation
____ Frequent somatic complaints – stomachaches, headaches, etc.
____ Nightmares or night terrors
____ Perpetrator of bullying or shunning
____ Perpetrator of physical, emotional, or sexual abuse
____ Poor self-esteem/feeling of guilt/shame/self-hatred
____ Problem with loss: divorce, death, etc.
____ Problems separating from parents
____ Sad, depressed, crying
____ School phobic/truant
____ Self-injurious behavior: cutting or other self-harm
____ Sexual orientation or gender identity issues/gender nonconforming
____ Superstitious or ritualistic behavior
____ Victim of bullying or shunning by peers
____ Victim of physical, emotional, or sexual abuse
____ Other: describe:_____

3. Has your child ever received psychotherapy/psychiatric services or counseling before? ____ Yes ____ No

If yes, please list below, giving reason, approximate dates, and type of treatment:

_____

_____

_____

4. Has your child ever taken medications for psychiatric or emotional difficulties? ____ Yes ____ No If yes, please indicate medications taken, when they were taken, and results:_____

_____

_____

5. Has your child ever been hospitalized for psychiatric reasons? ____ No ____ Yes If yes, please indicate approximate dates and location(s):_____

_____

_____

6. Any unusual traumas, stresses, or losses in your child's life? ____ No ____ Yes If yes, describe _____

_____

_____

7. Any history of psychiatric or emotional difficulties among immediate or extended family members?

____ No ____ Yes If yes, describe _____

_____

_____

School Information:

1. School your child attends:_____ Grade:_____

2. How long has your child been at this school?_____

3. Address:_____

4. Teacher's name:_____ Phone:_____

5. Has your child ever received a Child Study Team Evaluation or been tested for academic and/or behavioral concerns? ____ No ____ Yes If yes, please describe when and by whom:_____

_____

6. Does your child have an IEP or 504 plan? ____ No ____ Yes Classification:_____

7. Has your child ever been placed or recommended for a special academic setting such as special education or a gifted program? ____ No ____ Yes If yes, type of program:_____

8. Has your child received ongoing support services within the school such as occupational therapy, speech therapy, or counseling? ____ No ____ Yes If yes, type of services:_____

9. Please describe any academic services, outside of school, your child is receiving (for example tutoring or an afterschool program)?_____

_____

10. Has your child ever repeated a grade? ____ No ____ Yes If yes, grade(s)_____

11. Are there current academic problems? ____ No ____ Yes If yes, describe _____

_____

_____

12. How does your child's teacher describe his/her classroom behavior?_____

_____

Social/Interpersonal Functioning:

1. Please indicate who lives in your household at this time:

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. How do you feel your child gets along with other members of his/her family?_____

_____

_____

3. Describe child's involvement with extended family outside the house, if any:_____

_____

4. What are your child's primary interests?_____

_____

5. What kind/amount of friends does your child have?_____

_____

6. Does your child have any problems with friends/peers? ____ No ____ Yes If yes, describe _____

_____

7. Are there outside social, religious, or other communities that play a significant role in your child's life?

____ No ____ Yes If yes, describe _____

_____

Additional Information:

Is there other information that might be helpful in understanding your child?

_____

_____

_____

_____

CLIENT'S INFORMED CONSENT

I have chosen to receive psychological treatment from the Institute for Personal Growth and (therapist name)_____ for myself and/or my minor child. My choice has been voluntary and **I** understand that I may terminate therapy at any time.

Because psychotherapy is a joint effort between my therapist and myself, I will work with my therapist in a cooperative manner to resolve my difficulties. I understand there is no assurance that **I** will feel better.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and this may be necessary to help me resolve my problems.

I understand that confidentiality of records of information collected about me will be held or released in accordance with state and/or federal laws regarding confidentiality of such records and information.

I understand that state laws require that my therapist report all cases of abuse or neglect of minors or of the elderly.

I understand that state laws require that my therapist take mandated steps where there exists a danger to myself or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information and **I** will be informed of such circumstances prior to the disclosure.

I give permission to my therapist to disclose information and records necessary for continuation of treatment and processing of medical claims under current limits of state and federal law. I give permission for my therapist to file insurance forms on my behalf if requested, including electronic forms.

I understand that over the course of my treatment electronic communications may occur between myself and my IPG therapist and/or IPG's office staff, in the form of emails and/or or text messages, and that these communications may contain sensitive information about my healthcare. I understand that electronic communication, though encrypted for security, is not 100% secure.

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I understand that the Institute for Personal Growth is a group practice and that my therapist will participate in group and individual supervision where my case may be discussed with other therapists.

If, during my treatment at IPG, I transfer to a different therapist, or if I terminate treatment and return to IPG at a later time to see a different therapist, I give permission for my file, including clinical information, to be given to the new therapist.

I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one (1) year after all claims for treatment have been paid or treatment has been terminated, whichever is latest.

My signature attests that I have read the Informed Consent form and understood this information. I have received the attached forms.

Name of Client	Date
Signature of Client (if 14 yrs. or older)	Date
Parent/Guardian Name (if client is < 18)	Date
Signature of Parent/Guardian (if client is < 18)	Date

NOTICE OF PRIVACY PRACTICES

The Institute for Personal Growth and (Therapist Name) _____ are committed to keeping everything you share completely confidential. Whatever you speak about will not be shared with anyone else, outside IPG, without your written permission. However, there are certain limits to this confidentiality that you should know about.

1) If you have been referred by the court or any agency of the court, we may be required to furnish information to them.

2) If you are involved in certain kinds of litigation, such as worker's compensation, and inform the court of the services you have received from us, you may be waiving your right to have your records remain confidential. This would need to be clarified with your attorney.

3) If you threaten to harm yourself or someone else, we are obligated to inform potential helpers or victims. Information would be divulged only if we perceive that there is imminent danger to a readily identifiable victim, yourself, or the public. I am obligated to warn and protect if I believe you intend to carry out serious violence, even if you have not made a specific verbal threat.

4) If we have reason to suspect there is child abuse or neglect, we are obligated by law to report this to the appropriate state agency.

5) If we reasonably believe that a vulnerable adult is being abused, neglected, or exploited, we may report this information to the county adult protective services provider.

6) If you are a minor, your parents or guardians will be informed of your progress, if they ask. However, we will not reveal specific details of our conversations without your permission unless we determine that your safety is at risk.

7) Your health care insurance may require information to process claims or to authorize benefits.

8) If the New Jersey State Board of Psychological Examiners, the Board of Social Work Examiners, or the Board of Professional Counselor Examiners issues a subpoena, we may be compelled to testify before the Board and produce your relevant records and papers.

If you are concerned about some of your information, you have the right to ask us not to use or share it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we may not be able to agree to these

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limitations. However, if we do agree, we promise to comply with your wishes. You will be told if your information is shared per the privacy limitations listed above.

You have the right to request to receive confidential communication by alternative means and at alternative locations. For example, you could request that bills/statements be sent to a different address if you did not want a family member to know about them.

You can request to inspect, obtain a copy of, or amend information about yourself in our mental health or billing records. Under certain circumstances, your request may be denied, but you may be able to have this decision reviewed.

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, please discuss them with your therapist or Dr. Margaret Nichols, the Executive Director. You can also send a written complaint to the Secretary of the US Department of Health and Human Services.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent), and we will comply with your wishes about using or sharing your information from that time on. However, if we have already used or shared some of your information, we cannot change that. This form complies with federal regulations (HIPAA).

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Please sign and date this sheet to acknowledge that you have read and understood this notice of privacy policies.

Name of Client	Date
Signature of Client (if 14 yrs. or older)	Date
Parent/Guardian Name (if client is < 18)	Date
Signature of Parent/Guardian (if client is < 18)	Date

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Counseling
& Psychotherapy

Our Locations: Highland Park, NJ I Jersey City, NJ I Freehold, NJ

CONSENT FOR TREATMENT OF MINOR

I, _____ give permission to _____
(Parent or Legal Guardian) (Therapist)

to provide psychological treatment (assessment and/or psychotherapy) to

_____, my minor child.
(Name)

I have the right to rescind this permission at any time by notifying IPG and my therapist in writing. I also understand that psychological treatment requires the cooperation of all parties and that there is no guarantee treatment will be successful.

I am aware that the privilege of confidentiality remains with the legal guardian. All permission to release information to a third party must be given by parent/legal guardian. For the success of treatment, the confidences of my child may need to be maintained and not all information may be revealed to me. However, in situations that might indicate imminent danger or harm to my child or another person, I understand that I will be notified immediately.

_____
(Name of Parent or Legal Guardian)

_____ _____
(Signature) (Date)

_____ _____
(Signature of Minor Client if Age 14 or older) (Date)

_____
(Witness)

COLLATERAL CONTACT POLICY
Institute for Personal Growth

A collateral contact is either a third party contacted by your therapist on your behalf with your permission for the benefit of your therapy, or personal contact with your therapist that is not during your scheduled session time. This contact may be in the form of a letter, a telephone call, a fax or in rare occasions a face to face meeting. No third party collateral contacts will be made by your therapist without your prior written consent in the form of an authorization form provided by IPG and signed by you giving permission for the contact. No personal collateral contact will be billed to you without your prior knowledge and consent.

Collateral contacts of either kind will be billed at the discretion of your therapist at a rate of $40.00 per hour ($10.00 per 15 minutes, $20 per 30 minutes etc.) You cannot use your health insurance to pay for collateral contacts. In the event of a collateral contact, your therapist will prepare a bill for you outlining the contact and the cost. You will never be billed for a collateral contact without your prior knowledge and consent.

[ ] I have read and understand this policy.

_____

Clients Name (please print)

_____ _____

(Client's Signature) (Date)