

Counselor _____ Location _____ Client # _____

Client Information Form for Minors

(One form per individual, couple, or family is all that is necessary)

CLIENT (CHILD) INFORMATION

TODAY'S DATE _____

Name _____
Last First Middle Initial

Mailing address _____
Street City State/Zip code

DOB ____/____/____ Age _____ Male Female

Racial identity American Indian Asian African-American Caucasian Hispanic Middle Eastern

RESPONSIBLE PARTY

Name _____
Last First Mid Initial

Mailing address _____
Street City State/ZIP

Relationship to client _____

Home phone: _____ Preferred? Leave Message? Y N Email address: _____

Cell phone: _____ Y N OK to send text message? Y N

Work phone: _____ Y N

Employer _____ Job title/position _____

Highest level of education attained and what school _____

Religious or denominational preference (if applicable): _____

Member of a church? Yes ___ No ___ If Yes, which church _____

Name of Pastor, Minister, or member of the clergy _____

Emergency contact _____
Name Relationship to Client

Contact number _____

SPOUSE/PARTNER

Number of years together: _____

Name _____ DOB _____ Age _____
Last First

Relationship to client _____

Home phone _____ Cell _____ Work _____

Employer _____ Job title or position _____

Highest level of education attained _____ Email _____

HOUSEHOLD'S TOTAL INCOME

___ Less than \$20,000 ___ \$20-39,999 ___ \$40-59,999
___ \$60-79,999 ___ \$80-99,999 ___ \$100,000 or more

MEMBERS OF HOUSEHOLD

Name	Relation to Client	Sex	Age	Deceased?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

CLIENT EDUCATION

School and grade level _____
Teacher _____ Academic performance or GPA _____
Favorite subject _____ Least favorite subject _____
Extracurricular activities and hobbies _____

PRESENTING PROBLEM (See also the checklist of concerns on page 4.)

What brings you to counseling at this time?

Have you (or your family members) ever been involved in counseling? Yes No
If yes, name of counselor? _____ When? _____
Reason(s): _____

Is your child in treatment with another counselor at this time? Yes No
If yes, with whom? _____ Reason(s) _____

MEDICAL HISTORY/HEALTH CONDITIONS

Name of client's primary physician _____ Phone _____
Date of last physical _____ Date of last visit _____

Please indicate if your child has now or has had any of the following conditions:
___ Arthritis ___ Asthma ___ Back problems ___ Cancer
___ Chronic lung problems ___ Diabetes ___ Hearing problems ___ Heart problems
___ High blood pressure ___ Kidney problems ___ Stroke ___ Thyroid problems
___ Vision problems ___ Weight loss/gain ___ Chronic pain ___ Headaches
___ Stomach aches ___ Ulcer/gastrointestinal problems ___ Sexual functioning problems
___ Other _____

Please list all prescribed medications (medication, dosage, frequency, and name of prescribing physician)

Name of Psychiatrist (if applicable) _____ Phone _____

Check which of the following your child uses, and please note the amount and frequency of each:

- Caffeine _____
 - Coffee Sodas Other drinks Pills/supplements
- Alcohol/adult beverages _____ Tobacco _____

FUTURE APPOINTMENTS

Should we need to contact you regarding a future appointment, please indicate how we may do this if you are not available when we call. Initial all that apply.

- _____ Leave message with appointment day and time on voicemail
- _____ If no voicemail, leave appointment time with _____
- _____ Leave a message with callback number requesting you contact Samaritan Counseling Centers
- _____ Email appointment information
- _____ Text appointment information to my cell number

REFERRAL SOURCE

How did you hear about us? _____

If you were referred to us by a specific person, do we have your permission to thank them? Yes No

Name & Contact Information of Referral source (if applicable)

CLIENT NOTIFICATION OF PRIVACY RIGHTS/ HIPAA

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law”, HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA also applies to mental health client care.

By law, we are required to secure your signature indicating you understand this Client Notification of Privacy Rights document. If you have any questions about Samaritan Counseling Center’s Notice of Privacy Rights, please contact the Privacy Officer listed below.

Privacy Officer

Laurie Pierce, LPC
100 Missionary Ridge
Birmingham, Alabama 35242

Telephone: (205) 967-3660
Fax: (205) 991-4021
Email: info@samaritancec.org

PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE CLIENT INFORMATION AND CONSENT TO TREATMENT FORMS, INCLUDING THE CLIENT NOTIFICATION OF PRIVACY RIGHTS SECTION.

Client(s) (and/or Guardian) Signature

Date

<i>For SCCBham Office use only</i>			
<i>Client’s Consent/Fee Info Signed</i>	__Y__N__N/A	<i>Demographic Form</i>	__Y__N__N/A
<i>Consent for Minors</i>	__Y__N__N/A	<i>CC on File Necessary</i>	__Y__N__N/A
<i>HIPAA Offered/Signed</i>	__Y__N__N/A	<i>Initial Assessment Summary</i>	__Y__N__N/A
<i>Release of Information</i>	__Y__N__N/A	<i>Treatment Plan</i>	__Y__N__N/A
<i>Prayer or Spiritual Issues Discussed</i>	__Y__N__N/A	<i>Client Satisfaction Form</i>	__Y__N__N/A
<i>Suicidality & Homicidality Assessed</i>	__Y__N__N/A	<i>Discharge Summary</i>	__Y__N__N/A
<i>Insurance Information</i>	__Y__N__N/A	<i>Client Record Audit Date(s)</i>	_____

CHECKLIST OF CONCERNS

Please check any relevant concerns; initial if referring to more than one person.

THOUGHTS/FEELINGS/MOOD

- Anger/frustration/hostility
- Anxiety, nervousness
- Attention, concentration, distractibility
- Confusion
- Depression
- Disliking others
- Emptiness
- Euphoria
- Excessive worry
- Failure
- Fear
- Grieving (death, loss, divorce, etc)
- Guilt
- Hearing things other people don't
- Homicidal thoughts
- Intrusive thoughts
- Judgment problems
- Memory difficulties
- Negative thoughts
- Obsessive thoughts
- Oversensitivity to criticism
- Oversensitivity to rejection
- Panic attacks
- Perfectionism
- Sadness
- Seeing things other people don't
- Self-centeredness
- Self-esteem (low)
- Shyness
- Spiritual, religious, or moral issues
- Stress
- Sudden mood changes
- Suicidal thoughts
- Suspiciousness
- Temper problems
- Thoughts of hurting self or others

BEHAVIOR

- Aggression, violence
- Alcohol use
- Argumentative
- Avoidant
- Bedwetting
- Compulsive behavior/rituals
- Controlling
- Decreased/lack of sexual interest
- Defiance/disobedience
- Dependency, clingy
- Destruction of property
- Drug use: prescription, over-the-counter, street
- Eating problems
- Financial problems, debt
- Gambling
- Hyperactivity
- Internet problems
- Irresponsibility
- Isolation
- Legal problems
- Letting others take advantage of him/her
- Loss of appetite
- Loss of interest in what child used to enjoy
- Lying
- Nightmares/night terrors
- Not able to relax
- Overeating
- Pornography
- Preoccupation with sex
- Procrastination
- Purging
- Self-destruction/sabotaging
- Self-neglect
- Sexual dysfunction
- Sleep difficulty
- Smoking
- Stealing

- Threats
- Weight, gain/loss
- Withdrawal from others

FAMILY & RELATIONSHIPS

- Affair
- Childhood issues
- Divorce
- Friendships/ peers
- Housework/chores
- Interpersonal conflicts
- Parenting
- Problems w/ parents
- Problems w/ siblings
- Problems w/ teacher(s)
- Separation

ABUSE

- Abuse of alcohol
- Abuse of drugs
- Emotional abuse by another
- Emotional abuse of another
- Financial abuse
- Neglect
- Physical abuse by another
- Physical abuse of another
- Sexual abuse by another
- Sexual abuse of another
- Verbal abuse

WORK & SCHOOL

- Absenteeism
- Career concerns, goals, choices
- Difficulty with authority
- Difficulty with coworkers/peers
- Performance
- Procrastination
- School problems
- Tardiness

OTHER CONCERNS

- _____
- _____

Of the items check, which most concerns you? _____

I have no problems or concerns bringing me here.

(Note: The information requested in this form will be kept strictly confidential.)