Client Information Sheet—Child Client

Client's Name: ____Client's Date of Birth: ____________________

Client's Address: ____

City: ____ Zip: ____________________ Sex: Male Female Trans

Parent's name: ____ Relationship: _____________________

Parent's Home Phone: ____________________________ OK to leave message? _____________

Cell Phone: ______________________________ OK to leave message? _____________

Work Phone: _____________________________ OK to leave message? _____________

Email address: ____ Email o.k.? ____________

Alternate parent's name: _____________________________________ Phone: ______________________ Msg? _______

How did you hear about my therapy services? ____

Insurance Information: (Primary Insurance)

Name of Mental Health Insurance: _____________________________________Insurance Phone #: ______________________

Mental Health Claims Address: ____

Insured/Sponsor's Name: ____Insured's Date of Birth: ___________________

Insured/Sponsor's Address: ____

Insured/Sponsor's ID # (off of insurance card): ____

Group #: ___________________________ ***Client's*** Relationship to Insured: Self Spouse Child

Insured's Employer Name: ____

Do you have other insurance? Yes No

Name of Mental Health Insurance: ____Insurance Phone #: ____________________

Mental Health Claims Address: ____

Insured/Sponsor's Name: ____Insured's Date of Birth: ______________

Insured/Sponsor's Address: ____

Insured/Sponsor's ID # (off insurance card): _________________________ ***Client's*** Relationship to Insured: Self Spouse Child

Group #: ____________________ Insured's Employer Name: ____

SIGNATURE ON FILE

I attest that all of the information above is correct to the best of my knowledge. I authorize release of any medical or other information necessary to process claims to my insurance companies. I authorize payment of medical benefits to the physician or supplier for services described on insurance claims. I understand that verification of insurance benefits it not a guarantee of payment and that any unpaid balance is my responsibility.

____ ________________________

Signature Date

Blue Star
COUNSELING

Developmental/Social History Questionaire

Child's Name:_______________________________ Age:____________ DOB:________________

School:______________________________ Grade:__________ Grades Retained:_____________

Child currently lives with: ____

Form completed by: ____ Relationship: ______________

Family Members

Relationship	Name	Age / Sex	Occupation/ School Grade	Living in the Home? Y / N
Parent 1				
Stepparent				
Parent 2				
Stepparent				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Other Adults Currently Living in the Home:
Name:___________________________________ Age:_______ Relationship:____________________
Name:___________________________________ Age:_______ Relationship:____________________

If parents are separated or divorced, please describe visitation or co-parenting schedule: __________
____

Describe any significant conflicts between the parents: _______________________________________
____

Reasons child is being referred for counseling: ____
____
____
____

Any previous counseling (dates/therapist name):
____
____

Please complete page 2

Developmental History

Mother's Pregnancy:

Illness or Complications? ( ) Yes ( ) No
C-section? ( ) Yes ( ) No
Premature Delivery? ( ) Yes ( ) No
If so, gestational age at delivery:_________
Length of hospitalization after delivery: ________

Did the mother (during pregnancy):
Smoke? ( ) Yes ( ) No
Use Alcohol/Drugs? ( ) Yes ( ) No
Take Medications? ( ) Yes ( ) No

Was any of the following present during child's early childhood? Please check the appropriate boxes:

______Did not enjoy cuddling	______Difficult to comfort	______Colic
______Irritability	______Eating Difficulties	______Excessive Sleep
______Head Banging	______Seizures	______Difficulty Sleeping
______Demanding/Clingy	______Developmental delays	______Ear infections

Was the child adopted? ________ If yes, at what age? ___________ From what country? ___________
Please list what is known about care received before adoption?____________________________
____

Major history of learning or behavior problems at home or school?________________________________
____

Medical History

Any Childhood Illnesses? Please list:____
____
Hospitalizations/Operations? ____
Head Injuries? _______________________________ Eye Problems? ___________________________
Allergies? ____
Present Medical Conditions/Concerns:____
____

Current Medications:____ Reason(s): _______________
Doctor Prescribing:___________________________________ Phone #: ___________________________

Current Concerns

Please check any of the following that are concerns for your child:

______Reading	______Handwriting	______Does not Listen	______Destroys Property
______Bedwetting	______Forgets Easily	______School Phobia	______Comprehension
______Distractibility	______Easily Frustrated	______Poor Hygiene	______Soils Pants
______Math	______Tantrums	______Drug/Alcohol Use	______Poor Peer Relations
______Aggressive	______Talks Excessively	______Disorganized	______Frequent Accidents
______Poor Response to Discipline		______Mood Changes	

Type of discipline you use:____
Child's response to discipline:____
Child's interests/talents:____
Recent losses or changes in home:____
Family history of drugs/alcohol/mental illness (describe)?__________________________________
____
____
Any other information you feel would be helpful:____
____
____

Blue Star COUNSELING

Parent Observations and Symptom Check List

Child' name: ______________________________ Age: __________

Parent's name: ____________________________ Date: ____________

Behavior	None	Mild	Moderate	Severe
Poor impulse control				
Aggression toward others (physical/verbal)				
Inappropriately demanding and clingy				
Deceitful (lying, conning) behavior				
Sleep disturbances				
Hyperactivity				
Persistent nonsense questions, incessant chatter				
Difficulty with novelty and change				
Perceives self as victim (helpless)				
Intense displays of anger (rages that can't be soothed)				
Frequently sad, depressed, hopeless				
Extreme mood changes				
Lack of eye contact				
Cannot tolerate limits and external control				
Lacks trust in others				
Manipulative, controlling, bossy				
Lack of remorse or conscience				
Does not like to be touched				
Accident prone				
Poor hygiene				
Victimizes others (bully), seeks revenge				
Blames others for own mistakes or problems				
No stable peer relationships				
Indiscriminately affectionate with strangers				
Poor self-esteem				
Does not seem to listen when spoken to directly				
Victimized by others				
Learning disorders/problems in school				
Lack of cause and effect thinking				
Cruelty to animals				
Inappropriate sexual conduct and attitudes				
Pre-occupation or obsessions with an object				
Frequently defies rules (oppositional)				
Abnormal eating habits				
Destruction of property				
Consistently irresponsible				
Stealing				
Unusually fearful				
Grandiose sense of self-importance/entitlement				
Poor organization and planning skills				

Consent for Treatment of Minors

Client's Name:____ Date of Birth:____________________

I give permission for Kathryn Zentner, LCSW to provide mental health services for the above-named client and any family members who may be participating in a family therapy session. I understand these services may include assessment, and/or brief or long-term family therapy or individual counseling/psychotherapy.

- All records related to the client will remain confidential unless otherwise authorized by the client (or parent/legal guardian), a court order, or an emergency necessitating release of client-related information.

- Parents have the right to request information contained in their child's records. However, if the record includes contact with a parent (such as family therapy or family assessment sessions), the parent(s) participating in the session must provide consent before the content of the sessions can be shared.

- Please list all the child's legal guardians: Please list all legal guardians' phone numbers:

______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

- I understand that in signing this form I give Kathryn Zentner, LCSW permission to notify all legal guardians of the above therapy services.

The parent responsible for payment of any outstanding balances from services provided by Kathryn Zentner, LCSW is:

Parent/Guardian Name: ____

Street/Mailing address: ____

City/State/Zip: ____

I hereby certify that I am the managing conservator for the above named minor child and have the right to seek mental health services for my child.

____ ______________________________

Signature of Parent/Guardian Date

____

Printed Name of Parent/Guardian

Kathryn Zentner, LCSW

Licensed Clinical Social Worker

I truly appreciate the opportunity you have given me to be of professional service to you and/or your family. I am eager to receive your questions or concerns at any time. I look forward to a professional relationship with you.

My office policies are listed below. If you have any questions about them, please let me know.

OFFICE POLICIES

1. Sessions are 45 minutes long. Family or child play therapy sessions require extra preparation time and may be 30-40 minutes long, with the possibility of a parent "check in" time afterwards. You are expected to arrive at your appointment time.

2. My fee is $150 for the initial interview and/or assessment appointments, $125 for family therapy, and $125 for individual therapy. Longer sessions will be prorated based on the basic fees. Payment or co-payment is due at each session. Costs for court testimony are $500 per half day (or portion of a half day), payable in advance. Separate office policies are required for parents involved in custody proceedings.

3. Regular attendance at scheduled appointments is one of the keys to a successful outcome in counseling. When you make an appointment, I reserve your appointment time for you. You are expected to notify me at least 48 hours in advance if you cannot attend a scheduled appointment. **Any cancellations within 24 hours of your appointment time will assess a $45 cancellation fee *regardless of the reason for the cancellation***. If you fail to keep an appointment without notice, I will charge you a $75 "no show" fee. These fees cannot be billed to insurance. You may cancel an appointment by calling or texting (512) 497-2177.

   I am aware of this cancellation policy: __________ (initials)

4. I will bill your insurance when applicable and as requested by you. It is your responsibility to make sure I am a participating (in network) provider on your plan and to know the limitations of your coverage. Your insurance company may limit the number of sessions based on their assessment of medical necessity or other factors. **Benefits quoted by your insurance company are not a guarantee of payment.** You are responsible for any co-pays, deductible amounts, and any other fees that are not covered by insurance. Payment is due at the time of service unless you have made special arrangements with me. In some cases I may ask you to supply a credit card as a secondary form of payment in case your claim is denied or you have not met your deductible.

5. Insurance companies routinely ask for patient information, including diagnosis and treatment plans to authorize payment. When you request that I bill your insurance company for my services, you are agreeing that I can release this information to them.

6. If you have an emergency or have an urgent need to speak with me, you may leave a message in my confidential voice mail box by calling (512) 497-2177. I attempt to return all calls within 24 hours. If I am not able to return your call within a reasonable amount of time, or I am unavailable for a longer period of time (i.e. on vacation), you are responsible for seeking help from community resources or the local emergency room or psychiatric hospital.

7. Throughout our time together we will discuss your treatment goals for therapy. Therapy is a joint effort between the therapist and client, the results of which cannot be guaranteed. Progress depends on many factors, including motivation, effort, and other life circumstances, such as interactions with family, friends, and other associates. Unfortunately, there are no instant cures and therapist and client must work together to move the client in the direction the client wants to go. You are encouraged to discuss any concerns and/or questions about treatment with me at any time.

I agree that I will be responsible for the payment of all professional fees. I have read and understand the policies listed above. I have received a copy of these policies for my records.

Signature of client (or parent/guardian) ____ Date_______________

Printed name of client (or parent/guardian) ____

Name of client (if client is a minor) ____