Good Company Christian Counseling
& Life Coaching, LLC
2475 Collingwood Blvd.
Toledo, Ohio 43620
419-822-7319
Child

CLIENT INFORMATION AND POLICY STATEMENT

Welcome! As a new client, it is important that we provide you with information relevant to treatment, confidentiality, and office policy. Please read, sign and date the following Client Information and Office Policy statement. The therapist working with you will be pleased to respond to any questions you may have regarding treatment, confidentiality or office policy during your initial session.

APPOINTMENTS: Our entire staff makes every effort to be on schedule and to respect the busy lives of our clients. Appointments are usually scheduled for 50-minute sessions. Your appointment time is reserved especially for you and implies obligation of your presence. Both you and your therapist need to evaluate the process and progress of therapy periodically and renegotiate the need for further appointments. It is in your best interest to do so. It is the therapist's ethical responsibility to end the relationship when it is reasonably clear that the client is not benefiting from treatment.

CONFIDENTIALITY: Ohio law requires that issues discussed during the course of therapy with a psychologist or therapist be confidential, meaning that information you reveal will not be discussed with others without your knowledge and written consent. Information will not be sent or disclosed to others without a signed release from you. Exceptions to confidentiality include the following: situations of potential harm to oneself (suicide) or others (homicide); suspected child abuse or neglect; in the instance where the court may subpoena records, the release of confidential materials is, or maybe, required of your therapist.

PAYMENT FOR PROFESSIONAL SERVICES RENDERED: Please refer to Counseling Fees form.

CANCELLATIONS AND MISSED APPOINTMENTS: If you need to change your appointment, please allow 24-48 hour notice. This will allow us to schedule another client, needing care, in your reserved time. ***ALL MISSED APPOINTMENTS WITHOUT A 24 HOUR NOTICE ARE SUBJECT TO A $70.00 BROKEN APPOINTMENT FEE!***

OVERDUE ACCOUNTS: We understand that financial hardships may occur to all of us. If you cannot pay your bill because of unforeseen circumstances, individual payments can be arranged. If more than ninety days elapses without payment, unless arrangements have been made, we reserve the right to turn the account over for collection.

STAFF: Some therapists in this office are directly supervised by **R Carter Thomas, LISW-S** as required by Ohio law. She will have access to your case and file. You have the right to ask foran appointment with her at any time.

TELEPHONE: There is a 24-hour answering service that receives our calls. The telephone is listed at the top of this page.

Date

Signature

Good Company Christian Counseling
& Life Coaching, LLC
2475 Collingwood Blvd.
Toledo, OH 43620
(419) 822-7319

Release of Confidential Information To Managed Care Organizations

I _____ understand that Good Company Christian
(parent/guardian)
Counseling, LCC., will be discussing my case with

_____, Managed Care Organization. The purpose of the clinician's consultation with my Managed Care Organization will be to discuss diagnosis, goals for treatment and progress toward those goals. As a part of the release of information, issues to be discussed will be my family history, current personal liabilities and assets, which includes strengths and my physical, medical condition. The medical condition will involve reporting what medical treatment I am currently receiving including medications. The family history will involve issues such as composition of family of origin, illness in family of origin and my relationship to my family of origin. The issues to be discussed are my personal liabilities and assets which include my employment, access to a support network and ability to draw on other support networks for the purpose of reducing the reoccurrence of the current problem presented in therapy.

While the above information is an estimate of topics to be discussed, please keep in mind that it is not a limit to the topics discussed with your Managed Care Organization. In an effort to reserve some privacy, I **R Carter Thomas, LISW-S** will attempt to share only the information necessary for the approval of counseling sessions, reserving the right to not discuss the intimate details of counseling sessions.

Signed _____ Date _____
(parent/guardian)

Good Company Christian Counseling
& Life Coaching, LLC
2475 Collingwood Blvd.
Toledo, Ohio 43620
419-822-7319

CHILD CONSENT FOR TREATMENT

I _____, agree that my child, or the child whom I am
(parent/guardian)
legal guardian for, _____, can be seen for treatment by
(name of child)
_____ and/or _____.
(therapist) (supervised counselor)
I understand that I have a right to contact the therapist and/or counselor at any time.

I further understand that my consent may be withdrawn at any time through notification of the above mentioned therapist and/or counselor and through my dated signature of the withdrawal.

Date:_____

Signature of Parent/Guardian: _____

Signature of Witness: _____

I hereby withdraw my consent for treatment.

Date: _____

Signature of Parent/Guardian: _____

Signature of Witness: _____

MINOR PATIENT information (please print clearly & complete ALL info front & back)

Patient Name: _____
(first) (M.I.) (last)

Patient Address: _____
(street) (city) (state) (zip)

Patient's:
Home Phone:_____ Date of Birth:_____ Social Security Number:_____

Gender: ___ Male
___ Female

Parent / Guardian Name/s: _____
and
Work / Cell Phones: _____

Patient's School _____ School Status: _____
and
Address: _____

Patient's Primary Care Physician (PCP) _____
and (name) (phone)
Complete Address:_____

In Case of Emergency, contact: _____
(name) (phone) (relationship to patient)

BILLING INFORMATION

Person responsible for charges for this patient? Please complete the following information..
(other than insurance)

Name: _____ Relationship to Patient: _____

Address: __ Same as patient
__ Other:_____
(street) (city) (state) (zip)

Home Phone: (___)_____ Work Phone: (___)_____ Cell: (___)_____

Date of Birth: _____ Social Security Number: _____

Marital Status:_____ Gender: ____ Male ____ Female

Employer: _____ Employment Status: _____
Address: _____

I UNDERSTAND THAT (regardless of my insurance status) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION PROVIDED ON THE R CARTER THOMAS OFFICE POLICIES FORM AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

_____
Parent/Guardian Signature Date

NAME: _____ DATE: _____

Please list your **PRESCRIPTION MEDICINES and ALLERGIES:**
(IF NONE-please write N/A large over applicable section/s)

Start Date	Name of Medicine	How Much I Take	When I Take It	Used For	Refills
3-1-02	**Example**	**1 tablet/400mg**	**3 times a day**	**Arthritis**	**2**

ALLERGIES: (IF NONE-please write N/A over this entire section)

KEEP THIS ON HAND TO SHOW TO DOCTORS, PHARMACISTS,OR NURSES!!

CHILD/ ADOLESCENT PERSONAL HISTORY
(Ages 17 & Under)

CASE # _____

TO BE FILLED OUT BY THE PARENT OR GUARDIAN. THE INFORMATION THAT YOU PROVIDE TO US WILL BE VERY HELPFUL IN TREATING YOUR CHILD. PLEASE FILL OUT COMPLETELY. IF YOU HAVE DIFFICULTY WITH ANY OF THE QUESTIONS, YOUR CHILD'S THERAPIST WILL REVIEW THEM WITH YOU. THANK YOU!

CHILD'S NAME: _____ AGE: ____ DATE: _____

Person completing form for Client: _____ Relationship to Client: _____

	FULL NAME	AGE	LIVING IN THE HOME?	IF DECEASED, YEAR & CAUSE
CHILD'S MOTHER:				
CHILD'S FATHER:				
STEP-MOTHER:				
STEP-FATHER:				
BROTHERS & SISTERS: (Include Step & Half)				
Who else lives with you other than the ones checked above?				

Child was raised by? _____

PROBLEM: Describe the problems that child is having (behaviors, feelings, attitudes, school performance, etc.)):

_____

_____

_____

_____

What is the **main** problem that you are bringing child for? _____

How long has he/ she been having these problems? _____

Why do you think child is having these problems? _____

Whose idea was it to have child brought to this clinic for help? _____

What would you or they like to see done for child? _____

Describe how child's problems affect you, other family members and others: _____

_____

SYMPTOMS: CIRCLE THE NUMBERS OF ALL ITEMS THAT YOU BELIEVE FIT THIS CHILD:

1) Speech difficulties
2) Nervous habits/ behavior
3) Frequent headaches
4) Frequent stomach-aches
5) Sleep disturbance
6) Difficulty making friends
7) Difficulty keeping friends
8) Little interest in friends
9) Little interest in activities
10) Disrespectful/ argumentative
11) Temper tantrums
12) Ignores rules/ chores
13) Defies authority
14) Threatening behavior
15) Throws/ breaks things
16) Gets in frequent fights
17) Hurts animals
18) Sets fires
19) Steals
20) Lacks guilt/ remorse
21) Lies a lot
22) Breaks curfew often
23) Runs away
24) Skips school
25) Doesn't complete schoolwork
26) Has problematic friends
27) Underactive
28) Overactive
29) Acts before thinking
30) Short attention-span
31) Unable to sit still
32) Clowns a lot
33) Accident-prone
34) Sucks thumb
35) Wets the bed
36) Wets/ soils clothes
37) Bangs head
38) Grinds teeth
39) Separation problems
40) Worries a lot
41) Afraid/ fearful
42) Seems insecure
43) Withdrawn
44) Shy
45) Sad/ depressed
46) Cries frequently
47) Won't sleep in own bed
48) Seems too serious
49) Secretive
50) Looks "high" often
51) Keeps to him/ herself
52) Avoids family activities
53) In his/ her own world
54) Imaginary friends
55) Unusual behavior
56) Mentally slow
57) Nightmares
58) Acts spoiled
59) Too interested in sex
60) Disorganized/ messy

Please explain each item that you circled (You may also write on the back of this page):

_____

_____

_____

_____

_____

Has child ever expressed a wish that he or she were dead? _____ How recently? _____

Has child ever threatened or attempted to seriously harm self or others? _____

Please explain: _____

INTERESTS/ ACTIVITIES (Check all that apply to child):

___ Watch television	___ Play sports	___ Paint	___ Skate	___ Baby-sit
___ Be with friends	___ Ride bicycle	___ Draw	___ Write	___ Imaginary play
___ Play video games	___ Roller blade	___ Read	___ Scouting	___ Action figures
___ Listen to music	___ Build things	___ Sing	___ School	___ Dolls
___ Talk on telephone	___ Collect things	___ Dance	___ Crafts	___ Sew/ knit

Other interests/ activities: _____

Has child lost interest in activities that he/ she normally enjoyed? _____

EMPLOYMENT: Where does child work? _____ Hours per week: _____

Employment/ training/ work hours of each parent or guardian:

You: _____

Your spouse/ partner: _____

LEGAL HISTORY (Describe any legal problems that child has had in the past or present):

_____

EDUCATION: Name of school: _____ Grade: _____

School Address: _____ Phone: _____

Teacher: _____ Counselor: _____

Is child in any Special classes? _____ Since what grade? _____

Does child have any Learning Disabilities? _____

Has child repeated any grades? _____ Which ones? _____

Describe child's attendance: _____

Describe effort/ attitude toward school: _____

Describe child's *behavior* in school: _____

Describe academic performance: _____

When did school behavior or academic performance change? _____

Why do you think it changed? _____

Education of each parent or guardian: _____

_____

ETHNIC/ CULTURAL BACKGROUND (Child's): _____

RELIGIOUS/ SPIRITUAL BACKGROUND (Child's): _____

SEXUAL/ GENDER ISSUES (Describe any sexual or gender concerns you have about child):

_____

PREVIOUS MENTAL HEALTH OR ALCOHOL/ SUBSTANCE ABUSE TREATMENT:

OUTPATIENT: Has child seen a therapist or counselor for personal or family problems or alcohol/ drug treatment? _____

When, where? _____

Reason: _____

INPATIENT: Has child been in the hospital or Residential treatment for personal or for alcohol/ drug problems? _____

When, where? _____

Reason: _____

Were any of child's treatment experiences helpful? _____

What medications was child prescribed for emotional or behavioral problems? _____

Which of those medications were helpful? _____

List any of child's relatives (parents, grandparents, aunts, uncles,cousins, brothers, sisters) who have been hospitalized for personal or substance abuse problems:

Who, when, where? _____

_____

_____

PHYSICAL HEALTH: Child's Physician: _____

Physician's Address: _____ Phone: _____

Date child last saw physician: _____ Reason: _____

Results of Physician visit/ tests: _____

_____

Immunizations up to date? _____

Child's Height: _____ Weight: _____ Appetite: _____ Recent weight gain? _____ Loss? _____

Does child over-eat? _____ Binge? _____ Purge? _____ Energy/ activity level: _____

_____

If child has had any serious illnesses, injuries, surgeries or medical hospitalizations, please explain:

_____

_____

DEVELOPMENTAL HISTORY: Was your pregnancy desired? _____ Length of term: _____

Problems/ complications during pregnancy: _____

Did mother smoke, drink, use drugs during pregnancy? _____

Problems/ complications during delivery: _____

Explain if mother and child were separated after birth: _____

Other mother/ child separations: _____

Describe child as an infant/ toddler (happy, fussy, overactive, withdrawn, etc): _____

Age child sat up: ___ took steps: ___ spoke words: ___ spoke in sentences: ___ was weaned: ___ Fed self: ___

Age child was weaned: _____ began feeding self: _____ toilet-trained during day: _____ toilet-trained during night

Age that child was toilet-trained during the day: _____ during the night: _____ Problem now? _____

Age that child dressed self: _____ Age child tied own shoe-laces: _____ Age that child rode a 2-wheel bike: _____

ADOLESCENT MALES: Age that child'svoice changed: _____ Age that child developed body hair: _____

ADOLESCENT FEMALES: Age of first menstruation: _____ Age that breasts developed: _____

FAMILY RELATIONSHIPS: How do you get along with child? _____

How does your spouse/ partner get along with child? _____

If one or both of child's parents are out of the home, describe each one's current relationship with child:

Father: _____ Mother: _____

How does child get along with brothers & sisters? _____

RULES/ RESPONSIBILITIES/ CONSEQUENCES:

How does child deal with rules, responsibilities, chores? _____

Does child obey curfew? _____ Has child threatened/ attempted to run away or stay out all night? _____

How do you deal with child's misbehavior? _____

How does your spouse/ partner deal with child's misbehavior? _____

Do you or your spouse/ partner believe in physical discipline? _____

Has the family ever been involved with Protective Services? _____

Are there any situations at home that might have an effect on child's behavior? _____

_____

Drinking/ drug usage: IF CHILD *DRINKS* OR *USES DRUGS*, PLEASE ALSO COMPLETE THE NEXT PAGE.

TYPE OF DRUG	AGE OF 1ST USE	AT WHAT AGES WAS CHILD USING IT REGULARLY?	AVERAGE NUMBER OF DAYS USED EACH WEEK	USUAL AMOUNT USED ON AN AVERAGE DAY	NUMBER OF DAYS USED IN PAST 30 DAYS	AMOUNT USED IN THE LAST 48 HOURS	DATE CHILD LAST USED
Coffee, Cola, Caffeine pills							
Cigarettes							
Beer, Wine							
Liquor							
Marijuana							
Crack Cocaine							
Cocaine powder							
Heroin: Snort							
Heroin: Shoot (IV)							
Methadone							
Pain Pills: Type							
Codeine: Tylenol 3, 4 Other:							
Muscle relaxers: Soma, Flexeril Other -							
Tranquilizers: Valium, Librium Other:							
Glue Poppers Aerosols							
PCP, LSD Mescaline							
Meth-amphetamine Speed, Ritalin							
Phenobarbital Sleeping pills							
Steroids							
Other:							
Other:							

Therapist/ Credentials: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____