CLIENT QUESTIONNAIRE FOR CHILDREN AND TEENS

Parents: please fill out your child or teens information. Perhaps you can do it together if that seems appropriate. I am glad you are here. Thanks for your willingness to fill out this information.
If you have any questions, please ask me. ☺

Client Name:_____ **Date of Birth:**_____ **Gender:** ❑ Male ❑ Female

Current Address:_____

Current Phone:_____ **E-Mail Address:**_____

Insurance Co. & Plan: _____ **Group #:** _____

Co-pay _____ **Name and Date of birth of the insured parent** _____

Parents employer:

Please describe your child's current living situation:

_____

_____

Individuals Living in Household:

Name	Age	Sex	Relationship	Occupation

Referred By: _____

Is there a family faith that you find to be a source of strength for your child/teen?

_____

Medical History

Current Primary Care Physician: _____

Would you like me to contact your physician or a prior mental health provider? If so, please provide contact info:

_____

List any current medical problems or concerns: _____

_____

Current Medications (Please include prescription and over the counter medications):

Medication	Dose (mg)	Frequency	Reason for Taking	Date Started

Mental Health History

Previous Mental Health Services: ❑ Individual Counseling ❑ Family Counseling ❑ Couples Counseling

❑ Group Counseling ❑ Psychiatrist ❑ Psychiatric Medication ❑ Psychological Evaluation ❑ Other_____

Please Describe Previous Services:

Dates	Name of Professional	Reason for Treatment	How Was it Helpful?

Has Your Child or Teen ever been hospitalized for any emotional or psychiatric reason?
❑ Yes ❑ No

When?_____

Has Your Child or Teen taken any medication for psychiatric or psychological reasons in the past?
❑ Yes ❑ No
If Yes, Please List Below:

Medication	Dose (mg)	Frequency	Reason for Taking	Date Started

Has your child witnessed domestic violence or a high level of chronic family conflict?

Other than the above, please list traumatic situations she/he may have been exposed to in the past. If you are unsure about how to define trauma, please ask.

_____

_____

Child or Teen's functioning

School attended: _____ Grade level: _____

Special Ed services received if applicable _____

Is there anything I should know about your child or teens development?

Hours of sleep on a typical school night: _____

Approach to school work

Please place your child's initial next to the checked item if the term applies to them. If you want to reply on siblings, please place their initial next to it.

❑ Anxious ____ ❑ Passive, little initiative_____ ❑ Calm _____ ❑Fearful _____ ❑ Interested _____

❑ Bored _____ ❑ Self-directed_____ ❑ Refuses ____ ❑ Sloppy_____ ❑ Disorganized

❑Does only what is expected _____ ❑ Cooperative _____ ❑ Doesn't complete assignments

❑ Other, describe _____

Overall Performance at School:

❑ satisfactory ❑ underachiever ❑ overachiever ❑ other, describe _____

Feelings while at home:

❑ Anxious ____ ❑ Passive _____ ❑ Organized _____ ❑Fearful _____ ❑ Combative _____

❑ Bored _____ ❑ Depressed _____

❑ Other, describe _____

Relationships with friends:

❑ Spontaneous ❑ Follower ❑ Long-time friends ❑ Leader ❑makes friends easily ❑ difficulty making friends

❑ Other, describe _____

Relationship with Parents:

❑ Argues frequently ❑ Passive ❑ Loving ❑ Cooperative ❑ Combative ❑ Physical closeness ❑ Distant ❑ Depressed ❑ Other, describe _____

How would you describe your parenting style? :

_____

List your child's regular chores and routines_____

Consent For Treatment

I hereby consent to treatment with Linda Sheehan, LCSW I understand that I am responsible for full payment of the fee regardless of my health insurance coverage or benefits. I understand that full payment (or payment of the applicable co-pay) is expected at each session; that if I need to cancel an appointment, I must provide at least 24 hours notice; and that if an appointment is cancelled without such notice, I will be responsible for a cancelation charge of $40 as canceled sessions cannot be billed to insurance. I understand that if my account is in arrears, my biller may contact you to set up a payment plan.

Phone calls over 15 minutes will be billed at the rate of $95 an hour. In some cases, insurance may cover these services. I will inform you if I need to bill for a phone conversation we have just had. My attendance at special meetings/ Psychosocial evaluations can be very informative and helpful in working with your child. I bill an hourly rate of $95 and do not charge travel time unless the location is more than 15 minutes from my office. Once again, sometimes these services are covered but often they are not.

Counseling is confidential. I will use and protect your information in compliance with applicable state and federal law. Information obtained during counseling sessions will not be disclosed to anyone outside the session without your knowledge and written consent, with the following exceptions: if I believe that you present an imminent, serious risk of injury or death to yourself or another; if I have reasonable cause to believe a child's well-being or safety is compromised; if I have reason to believe that an individual who is protected under the Illinois Elder Abuse and Neglect Act has been abused, neglected, or financially exploited; or if I receive a valid court order signed by a judge.

Important note regarding confidentiality: If this is court-involved/ordered therapy, the normal assurances of confidentiality do not apply. However, every effort will be made to seek releases of information and keep information on a need to know basis.

Fee Agreement:

I, _____have agreed to the mutually decided amount of $110 per 50 minute session, or $150 for initial evaluation. I have discussed this form with Linda and I understand and agree to the terms outlined above. If I am on your insurance panel, **I will accept the contracted amount and whatever co-pay has been determined by your insurer.** Additionally, the fee for writing letters, reports, or completing assessments other than those requested by your insurer is $95 an hour. This is not billable to insurance.

Communication Agreement:

I give Linda Sheehan permission to contact me to arrange appointments on the email address and phone I listed on the first page. Please initial here: _____

Please note: Email/text communication is not HIPPA compliant. I will not be sending you or your family any clinical information in this way, just appointment info.

No I do not give permission to use the communication info provided on page one.

I would prefer to be contacted in the following manner: _____

_____ _____

Client's Signature Date Parent/Guardian Signature Date
(if client is under 18)

Note: **Confidentiality cannot be guaranteed in situations involving insurance or other third party reimbursement where consent is given for clinical information to be provided to the insurance or third party, with the handling and confidentiality of such information by insurance or third party being beyond the control of this office.**