Minor Client Packet
HeadSpace Counseling
1401 N. Central Expressway Suite 105 Richardson, TX 75080
Please note: the information you provide here is protected, confidential information

Client/Minor Name:
First_____Middle:_____Last:_____
Address:_____City:_____State:_____Zip:_____
Minor's mobile:_____May we leave a message? □Yes □No
Home Phone:_____May we leave a message? □Yes □No

Names of parents/guardians:

Mother Name:
First_____Middle:_____Last:_____
Address:_____City:_____State:____Zip:_____
Email:_____Mobile:_____
May we email you? □Yes □No **Please note: Email is not considered to be a confidential form of communication.*
Father Name:
First_____Middle:_____Last:_____
Address:_____City:_____State:____Zip:_____
Email:_____Mobile:_____
May we email you? □Yes □No **Please note: Email is not considered to be a confidential form of communication.*

Parents: □ Married □ Separated □ Divorced
If divorced, what is legal custody arrangement?_____
Child's Birth Date:_____Age:_____Gender: □ Male □ Female
School:_____Grade:_____
Pediatrician:_____Phone:_____
Psychiatrist (if any):_____Phone:_____
Siblings:
Name:_____Age:_____Grade:_____
Name:_____Age:_____Grade:_____
Name:_____Age:_____Grade:_____
Name:_____Age:_____Grade:_____

Please list the reasons you are seeking counseling:_____
_____
_____
Referred by (if any):
_____

COUNSELING AND/OR PSYCHIATRIC HISTORY

Has your child or family previously received any type of mental health services?
□ No □ Yes, previous therapist/practitioner:

_____

If yes, briefly describe the
experience:_____

_____

Is your child currently taking any prescription medication? □ No □ Yes If yes,
please list, include dosage and
dates:_____

_____

Has your child ever been prescribed psychiatric medication? □ No □ Yes
If yes, please list, provide reasons and dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child's current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any health
concerns:_____

2. Did your child meet all developmental milestones (i.e. crawling, walking,
talking…etc.)? □ No □ Yes If no, please explain:

_____

_____

3. How would you rate your child's current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please
describe:_____

4. What types of physical exercise does your child
get?_____

_____How often per
week?_____

5. Please list any difficulties your child might be experiencing with appetite or eating
patterns._____

6. Is your child currently experiencing overwhelming sadness or depression? □ No □Yes
If yes, please describe, noting
dates/duration:_____

_____

7. Has your child ever, or is he/she currently, experiencing self-harming thoughts?
□ No □ Yes If yes, please describe, noting
dates/duration:_____

_____

8. Is your child currently experiencing anxiety, panic attacks or phobias? □ No □ Yes
If yes, please describe, noting
dates/duration:_____

_____

9. Describe any changes or stressful events your child may have experienced recently:

10. Describe any trauma history that your child may have experienced:

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following:
Please Circle List Family Member
Alcohol/Substance Abuse yes/no……
Anxiety yes/no……
Depression yes/no……
Domestic Violence yes/no……
Eating Disorders yes/no……
Obesity yes/no……
Obsessive Compulsive Behavior yes/no……
Schizophrenia yes/no……
Bipolar Disorder yes/no……
Suicide Attempts yes/no……

ADDITIONAL INFORMATION

1. Briefly describe your child's academic strengths and challenges, noting any specific school accommodations (i.e. 504, Special Education, IEP):

2. Briefly describe your child's social functioning, including aggression or specific behavioral issues, noting any concerns you may have:

3. Do you consider your family and/or your child to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

4. What do you consider to be some of your child's strengths and weaknesses?

5. Please describe any concerns with family relationships:

6. Please describe how discipline is handled in your family (for example, time outs, loss of privileges, spanking, etc.) and any concerns you may have related to discipline:

HeadSpace Counseling: Informed Consent for Minors

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

· _**Abuse/Neglect of Children and Vulnerable Adults** If the counselor becomes aware during the course of treatment of any abuse/neglect or danger of abuse/neglect to a child (or vulnerable adult), then the counselor is required to report this information to the appropriate social service and/or legal authorities.

· _**Minors/Guardianship** Parents/legal guardians of non-emancipated minors have the right to access records, however it is important to note that this may affect your child's ability to fully trust in the counseling process.

· _**Insurance Providers** (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

· _**Subpoena** In the event that your counselor receives a subpoena from a court of law. You will be notified in the event that this occurs.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Signature:_____Print:_____Date:_____

CANCELLATION POLICY

If you need to cancel an appointment, you must give **24--hour** notice in order to avoid a missed appointment fee. A missed-appointment fee (same charge as your appointment) is charged for appointments that are cancelled with less than a 24-hour notice, unless an emergency arises**. Please discuss with your therapist if this is the case.** Thank you for your consideration regarding this important matter. *Please sign here to indicate that you understand and agree to this policy:*

Signature:_____Print:_____Date:_____

COUNSELING SESSIONS AND FEES

You are responsible for payment at the time of service. Fees are paid directly to your counselor. If you are late, your session will end at the time it was scheduled to end. Counseling fees are $120 per individual session and $140 per family or couples session unless otherwise agreed upon. Reduced fee services are available on a limited and as-needed basis.

CONSENT TO TREAT

Please sign below to indicate that you have read ALL the above policies and that you understand and agree to comply with them. Your signature indicates that you have had a chance to ask your counselor any questions you might have about these policies and that your questions have been satisfactorily answered. You agree that you are personally responsible for all financial obligations incurred. You also consent to receive treatment by a HeadSpace counselor.

Signature:_____Print:_____Date:_____

AUTHORIZATION TO TREAT MINORS

I/we,_____(name of parents/guardians), give my/our permission to HeadSpace Counseling to see my/our child/custodian, _____ (name of minor child), for counseling with or without me being present in the same session. I/we understand that we are the holder of confidential privilege. However, in the interest of developing a trusting relationship between the counselor and my/our child, I/we give the counselor permission to reveal or withhold information that in his/her clinical judgment is necessary to best help and treat my/our child.

The only exception to this agreement would be in the case of

_____

_____

(Signature parent/guardian) (date)

Print name of parent/guardian:_____

_____

(Signature of minor) (date)

Print name of minor:_____

CREDIT CARD AUTHORIZATION FORM

HeadSpace Counseling

Name On the Card _____

Type of Card : Visa____MasterCard____AmEx____Discover____Other ____

Card # _____

Expiration Date _____

Security Code _____

Billing Zip Code _____

Phone Number _____

Amount to Be Charged Per Session _____

Client Name _____

I agree to allow HeadSpace Counseling to charge the above card for the amount indicated on this form for each session, as well as in the event I have not given at least 24 hour notice for a cancellation or no-show.

Signature:_____ Date: _____