Child and Adolescent Form

Session Requested By: _____

Clients

Name_____:

Address_____

City:_____State_____Zip_____

Home phone_____

Emergency Contact_____

Relationship to Emergency Contact_____

Phone number of Emergency Contact_____

Attendees: _____

Attendees_____

Date of Birth_____

Grade_____

School_____

Client Lives with: Both Parent Mother

Father Other_____

Mothers Name

Date of Birth

Address

Home Phone	Cell Phone
OK to leave a message Yes No	Ok to leave a message Yes No

Email

Employer

With my signature, I am acknowledging I am legally authorized to consent to mental health services, medical services, and/ or psychological evaluation for my minor child and I am legally authorized to make mental health and medical treatment decisions' regarding his/her care that include but are not limited to care described on these documents. Additionally, I agree to make known to Alicia Kruger, LPC immediately should a change occur, through divorce, custody or other, to my ability to legally authorize to consent to treatment for my minor child.

Signiture_____Date_____

Fathers Name

Date of Birth

Address

Home Phone	Cell Phone
Ok to leave a message Yes No	Ok to leave a message Yes No

Email

Employer

With my signature, I am acknowledging I am legally authorized to consent to mental health services, medical services, and / or psychological evaluation for my minor child and I am legally authorized to make mental health and medical treatment decision's regarding his/her care that include but are not limited to care described on these documents. Additionally, I agree to make known to Alicia Kruger, LPC immediately should a change occur, through divorce, custody or other, to my ability to legally authorize to consent to treatment of my minor child.

Signiture_____Date_____

Providers Involved in My Child's Care

Primary Care Physician_____ Phone_____

Psychiatrist_____: Phone_____:

Other:_____ Phone_____

Developmental History

Normal Pregnancy Yes No Was your child Adopted Yes No If so, at what age_____

Age at which the following occurred

Sat	Talked
Crawled	Walked

Other Information:

Education

Regular Education Classes Yes No Special Education Classes Yes No Talented/Gifted Yes No

504 Modification/Accommodations Yes No AP Classes Yes No

Held back a grade Yes No	Truancy Yes No:	Dropped out Yes No
School Refusal Yes No	Difficulties with peers Yes No	Difficulties with Adults Yes No

Mental Health History

Prior mental health counseling Yes No When:

Prior psychological or psychiatric evaluation Yes No When

Hospitalization for mental health Yes No	When:
Reason for hospitalization:	

Diagnoses:

Name of Facility

Any other information regarding mental health history:

Family History of Mental Health and/or Substance Abuse	Yes No	

Any of the Following Sources of Distress in my Childs Life

_____Anxiety
_____Depression
_____Selective Mutism
_____Obsessions
_____Compulsions
____Suicide Attempts
____Difficulties with Parents
____Difficulties with Siblings
____Difficulties with Peers
_____Skin Picking
_____Repetitive Hair Pulling
_____Self Harm/Self Abuse
_____Phobias
_____Suicidal Thoughts
_____Sadness
_____Starts Fires
____non compliant
____Irritable

_____Concentration Difficulties
_____Change in Energy Level
_____Isolation
_____Social Withdrawl
_____Binging/Purging
_____Weight
_____Family Violence
_____Hallucinations
_____Alcohol Abuse
_____Sleep difficulties
____Lying
____Emotional Eating
_____Panic Attacks
_____Mania
_____Parental Divorce
_____Grief and Loss
_____Frequent Moves
_____Issues with the Law
_____Compulsive Shopping
_____Phobias

Medical/Psychiatric

Current Psychiatric medication

Who Prescribed:

Please List any medical conditions::

Medications taking for medical conditions:

Who prescribed:

My goal for my child in counseling

What are you seeking counseling for:

What changes would you like to see

My childs strengths

Cancellation Policy

Your scheduled appointment time is time reserved just for you. **Missed or cancelled appointments without 24 hour notice will be charged to the client at the full office rate of $180 for that appointment.** Should you need to cancel your appointment time please call 24 hours in advance to avoid being charged. Insurance is not responsible for and will not pay for missed or late cancalled appointments. Client may cancel/reschedule an appointment by calling 512-658-7704.

Client Signature_____Date_____

Consent for Treatment

I give my consent for the completion of my initial evaluation and provisions of treatment as necessary by Alicia Kruger, LPC. I understand that no promises have been made to me as to the result of treatment by Alicia Kruger, LPC. If I have any questions about any aspect of my treatment or therapy I will discuss them with Alicia Kruger, LPC.

Signature below indicates informed consent for treatment

Name of Client_____

Name of Guarding giving Consent_____Date_____

Client Acknowledgment of Understanding and Agreement

Client Name:_____
Parent/Guardian Name:_____

1. HIPAA.

I acknowledge that Alicia Kruger, LPC has provided me with a written copy of Client Policy. I have reviewed this policy and by signing below acknowledge both my understanding of and agreement with the policy.

Client signature or Parent/Guardian signature_____
(Date)

2. Notice of Privacy Practices

I acknowledge that Alicia Kruger, LPC has provided me with a written copy of Notice of Privacy Practices. I have reviewed this notice and by signing below acknowledge both my understanding of and agreement with the policy.

Client signature of Parent/Guardian Signature_____

Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that **Alicia Kruger, LPC** communicates financial and/or medical information to you in confidence by a particular method or certain locations.

In order to protect the privacy and confidentiality of your information; please complete the following which tells me how you would like to be contacted.

I wish to be contacted in the following manner (check all that apply):

Phone Communications

____ Home Telephone Number _____

____ Work Telephone Number _____

____ Cell Phone Number _____

____ Leave message with your name and call-back # on answering machine

____ Leave message with medical information on answering machine

Written Communication

___ Mail information to my home address on file

___ Mail information to other address:

********(to request for communication via E-mail or Text message please read and sign Consent for Unencrypted Communication document)********

CONSENT TO USE UNECRYPTED E-MAIL OR TEXT

It is very important that you are aware that computer e-mail, texts, and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on Alicia Kruger, LPC laptop is encrypted, e-mails and e-faxes are not. It is always a possibility that e-faxes, texts, and e-mail can be sent erroneously to the wrong address and computers. . E-mail messages on your computer, your laptop, IPad, phone or other devices have inherent privacy risks – especially when your e-mail access is provided through your employer or when access to your e-mail messages is not password protected.

Alicia Kruger, LPC laptop is equipped with a firewall, a virus protection and a password, and all confidential information from the computer is backed up on a regular basis onto an encrypted hard-drive. Please, note that e-mails, faxes, and texts are all part of your clinical records. Please notify Alicia Kruger, LPC if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, it will be assumed that you have evaluated the risks and made an informed decision, Alicia Kruger, LPC will view it as your agreement to take the risk that such communication may be intercepted, and your desire to communicate on such matters will be honored. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

Patient's Name: _____
Cell Phone Number: _____
E-mail Address: _____
Patient's Signature: _____

Alicia Kruger, LPC will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form.

By your signature below, you agree to be communicated in the above manner.

Patient Signature _____ Date_____

Patient Name _____