Family Christian Counseling Center
1300 E. Missouri, Phoenix AZ 85014
(602) 325-1233
www.familycccp.org

REGISTRATION FORM – CHILD/ADOLESCENT (Demographic insurance information)

Today's Date_____
Child's Name: _____ DOB: _____ Age: _____

Child's Primary Residence: _____ City: _____ Zip: _____
Caregiver (s) at this address: _____
Okay to send billing/treatment information to this address? Yes ☑ No ☐

Second Residence _____ City: _____ Zip: _____
Caregiver (s) at this address: _____
Okay to send billing/treatment information to this address? Yes ☑ No ☐

Relationship Status of Child's Parents: ☐Married ☐Divorced ☒Separated ☐Widowed ☐Other

If divorced, what is the custody agreement?
Custodian Parent: ☐Mother ☐Father
Joint Physical Custody: ☐50/50 ☐NON 50/50: ☐Mother ☐Father
Sole Physical Custody: Physical custodial parent: ☐Mother ☐Father
Non Legal/Physical Custodian Parent's Visitation Rights:
_____
_____

Mother: _____ Father: _____
Occupation: _____ Occupation:_____
Employer: _____ _ Employer: _____
Home phone: _____ Home phone: _____
Cell phone: _____ Cell phone: _____

Referred by: ☐Physician ☐Friend ☐Google Ad ☐Website

☐Other _____

I give permission to receive messages via ☒Email _____

☐Text_____ ☐Phone _____

I would like to receive the quarterly FCCCP Electronic Newsletter. ☐Yes ☐ No

Parent/Legal Guardian: Signature_____ Date:_____

Parent/Legal Guardian: Signature_____ Date:_____

Office Policies and Consent for Treatment

Welcome to the Family Christian Counseling Center of Phoenix. This document contains important information about our professional services and business practices and will serve as a therapeutic contract.

About the Therapy Purpose and Process

- An important part of child therapy includes regular meetings with parents. And when involved in attachment therapy the parent is generally involved in the therapeutic process. **We are committed to the benefit and health of the entire family.**

- It is important for you to know that therapy has risks and benefits. Therapy has been shown through research to be beneficial to children. Although there are no guarantees about the outcomes of therapy, children often demonstrate a reduction in concerning behaviors and an increase in emotional well-being.

- Trust between client and therapist is vital to the therapy process, even for young children. Therefore, I will not share the specifics of what your child/adolescent has disclosed to me without the child's consent, unless there is a risk of harm to self or others. I will share with you general themes and treatment progress and will encourage your child to share important information with you as well.

- Litigation: Although my responsibility to your child may require my involvement in conflicts between parents, I request your agreement that my involvement will be strictly limited to that which will benefit your child. This means that you agree that you will not attempt to gain an advantage in any legal proceedings between you and the child's other parent (guardian) regarding my work with your child.

- **If you have information that you want me to know before a session with your child, please email or call me 24 hours before the session so that I have time to receive the information and plan the session accordingly.**

Cancellation Policy

A 24 hour notice is required for changes in appointments. Cancellations with less than 24 hours notice will incur a charge of 75% of the fee for service. No-shows and missed appointments incur a **100% of the fee for service**.

Specifics about Therapy

All therapists at the Family Christian Counseling Center of Phoenix are licensed with the State of Arizona, Board of Behavioral Health Examiners, as Licensed Associate Professional Counselors, Licensed Associate Marriage and Family Therapists, Licensed Professional Counselors, or

Licensed Marriage and Family Therapists. Each therapist holds a Masters Degree in Counseling with various specialties including the treatment of early complex trauma/reactive attachment disorder. The therapists are trained in and use various modalities, such as Play Therapy, Sand Tray, PCIT (Parent Child Interaction Therapy), the Neurosequential Model of Therapeutics, Filial Therapy, and EMDR (Eye Movement Desensitization Reprocessing), Theraplay and EFT (Emotionally Focused Therapy) as part of traditional "talk therapy."

Duty to warn or protect:
Based on case law, therapists are required by law to at least warn a responsible party if a patient or client makes a threat against a given individual(s). The warning communication will be limited to those individuals who absolutely need to know and designed to provide only information necessary to protect the potential victim(s).

Report of suspected child abuse:
Therapists serving children and adolescents are mandated by law to report any suspected physical abuse, sexual abuse, and/or neglect which appears to have been inflicted upon such minor by other accidental means or which is not explained by available medical history. The mental health provider shall immediately report such suspected abuse to a Police Officer or to Child Protective Services of the Department of Economic Security.

Custody/Guardianship

- Consent for services can only be authorized by a current legal guardian.
- For divorced parents, consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required. (A copy of the divorce decree must be included in the client file indicating the custodial arrangement).
- Permission from both parents, regardless of the custodial arrangement is the preferred practice of this office.

Payment and Fees:

- Payment is due at the beginning of each session (cash, check or credit card).
- Fees range from $110 to $140 depending on therapist.
- Some therapists chose to begin with a 75 minute intake session that will be pro-rated.
- Sessions are 45-50 minutes (clinical hour). Longer sessions may be pre-arranged and will be pro-rated.

Other fees *not* covered by insurance: (you will be billed directly for services below):
(Fees will be pro-rated)
Phone calls (with parent/caregiver)…… **$100/ hour**
Telephone consultation with other professionals at client's request..…….. **$100/ hour**
Other services (letters, complete forms, report writing, end of year tax docs)……..**$100/hour**

Legal: attorney calls, reports, testimony preparation & court appearances……	**$200/hour**
Preparation of Copies of Client Records……..…….	**$50.00/hour**
Returned Check Fee……..……	**$35.00**

Payment is made to the Family Christian Counseling Center of Phoenix (FCCCP).

I (name) _____ have read and understand the no show and cancelation policies of the Family Christian Counseling Center of Phoenix. In the event of default, I promise to pay my balance, together with all costs of collection.

I hereby agree to pay the fee according to (please mark one below):

☐ Intake Visit
☐ Standard Fee
☐ Group Fee
☐ No Show/Cancellation Fee (less than 24 hours)

CONFIDENTIALITY:

In most cases (see "Exceptions to Confidentiality" below) communications between client and therapist will be held in strict confidence - unless you provide your therapist written permission to release information about your treatment. **If you participate in couples or family therapy, the therapist will not disclose confidential information about treatment to a third party (other than to a third-party payer) unless all treatment participants (18 or older) provide written authorization to release such information.**

Exceptions to Confidentiality
Therapists are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse. Therapists are also required to break client confidentiality when it has been determined that a client presents a serious danger of physical violence to another person. A therapist may break confidentiality when she believes a client is likely to be dangerous to him or herself.

Consultation: Therapists at the Family Christian Counseling Center of Phoenix participate in supervision of their clients with their clinical supervisor, Deborah Pettitt (602-325-1233). All licensed associate counselors are required by the Arizona Board of Behavioral Health to participate in supervision. We occasionally consult with other professionals regarding our clients; however, our client's identity remains completely anonymous, and confidentiality is fully maintained.

E - Mails, Cell Phones, Computers and Faxes:
Individuals may choose to contact me via email, fax or cell phone. In doing so, they agree to the understanding that email, fax and cell phone communication are not guaranteed confidential methods of communication, and they are, by choice, relinquishing their rights of confidentiality.

Maintenance of records:

All individuals receiving behavioral health services are clients of Family Christian Counseling Center of Phoenix. All records will be kept by Family Christian Counseling Center of Phoenix. According to Professional Standards your records will be kept for three (3) years after the last contact with you and either the complete record or a summary of it will be kept for nine (9) years. Records involving children will be kept for three (3) years after their 18th birthday. The content of these records should include personal data, dates of service, types of services, fees, reports, and other supporting data as may be appropriate (APA, 1993).

In the case that the Family Christian Counseling Center of Phoenix would close, patients will be informed ninety (90) days prior to such termination, and a request will be sent to the patient as to where they want their medical records sent to for the purpose of continuity of care. If it is an inactive patient, the notice will be sent to the last address on record to inform the patient as to the future location of their medical records and that the patient can access these records. If records are not claimed after the above time guidelines, the records will be destroyed. If the practice is sold, and the records do not remain in the same physical location, the patient will be informed as mentioned above and records will be transferred as per patient's request (ARS-32-3211A).

The Center will respond to requests for medical records within fourteen (14) days of such requests for active patients. If the request is for an inactive record, such requests might take longer due to the time that it might take to retrieve the records from the storage facility. Patients have the right to access their records as per State, Federal, and Professional Standards. You will need to provide the office with a written request for medical records.

Consent to Treatment:

Your signature below indicates that you have had the opportunity to read and review the information in this three page document and that questions regarding your care have been satisfactorily answered. Furthermore, it indicates your willingness to abide by its terms and that you agree to participate in treatment. A copy of this document will be provided at your request.

Parent or Legal Guardian: Signature_____ Date:_____

Parent or Legal Guardian: Signature_____ Date:_____

Full Name of minor: _____DOB _____

Relationship: _____

For Office use only – verification that client has read and understands informed consent document

Authorized representative: Signature _____Date: _____

.

Client Rights

Family Christian Counseling Center shall ensure that:

A client has the following rights:

1) To be treated with dignity, respect, and consideration;
2) Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
3) To receive treatment that:
   a) Supports and respects the client's individuality, choices, strengths, and abilities;
   b) Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's general consent; or as permitted in this Chapter; and
   c) Is provided in the least restrictive environment that meets the client's treatment needs;
4) Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;
5) To submit grievances to center staff members and complaints to outside entities and other individuals without constraint or retaliation;
6) To have grievances considered by Family Christian Counseling Center in a fair, timely, and impartial manner;
7) To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;
8) To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;
9) To have the client's information and records kept confidential and released only as permitted under R9-20-211(A)(3) and (B);
10) To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
    a) For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
    b) For a client receiving treatment according to A.R.S. Title 36, Chapter 37;
    c) For video recordings used for security purposes that are maintained only on a temporary basis; or
    d) As provided in R9-20-602(A)(5);
11) To review, upon written request, the client's own record during the center's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211(A)(6);
12) To review client rights at the center:
13) To be informed of all fees that the client is required to pay and of the center's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;

14) To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment;
15) To be offered or referred for the treatment specified in the client's treatment plan;
16) To receive a referral to another professional if the center is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
17) To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. § 36-512;
18) To be free from:
    a) Abuse;
    b) Neglect;
    c) Exploitation;
    d) Coercion;
    e) Manipulation;
    f) Retaliation for submitting a complaint;
    g) Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;
    h) Treatment that involves the denial of:
        i) Food,
        ii) ii. The opportunity to sleep, or
        iii) The opportunity to use the toilet; and
        iv) Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;
19) To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
20) To control the client's own finances except as provided by A.R.S. § 36-507(5);
21) To participate or refuse to participate in research or experimental treatment;
22) To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;
23) To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility.

I have read and understand the above Client Rights

Signature: _____ _____

Client Name **Date**

Please Read Carefully

THIS NOTICE PROVIDES YOU WITH INFORMATION ABOUT HOW YOUR CHILD'S PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED BY THIS PROVIDER, AS WELL AS YOUR RIGHTS REGARDING YOUR CHILD'S PHI. YOUR CHILD'S PHI INCLUDES INFORMATION WHICH RELATES TO YOUR CHILD'S PAST, PRESENT OR FUTURE HEALTH, TREATMENT OR PAYMENT FOR HEALTH CARE SERVICES.

1. LEGAL DUTY TO SAFEGUARD YOUR *PROTECTED HEALTH INFORMATION* (PHI).

The Health Insurance Portability and Accountability Act (HIPPA) requires me to:

- Keep your medical information private.
- Give you this notice describing my legal duties, privacy practices and your rights regarding your medical information.
- Follow the terms of the current notice.

I have the right to:

- Change my privacy practices and terms of this notice at any time, provided that the changes are permitted by law.

Notice of Change to Privacy Practices:

- Before an important change is made in my privacy practices, I will change this notice and make the new notice available upon request.

2. USE AND DISCLOSURE OF YOUR PHI

The following section describes different ways that your PHI may be used or disclosed. For some of these uses or disclosures, I will need your prior authorization; for others, I do not. I will not disclose your child's PHI for any purpose not listed below without your specific written authorization. If you choose to sign an authorization to disclose your child's PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization).

Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your child's PHI without your consent for the following reasons:

- ***FOR TREATMENT:*** I may disclose your PHI to other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist. I may disclose your PHI to your psychiatrist in order to coordinate your care.
- ***FOR PAYMENT:*** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. I may also provide PHI to my business associates, such as my billing company, Comprehensive Billing Services, and others that process my health care claims.
- ***FOR HEALTH CARE OPERATIONS:*** I may use and disclose your PHI to operate my practice.

ADDITIONAL USES AND DISCLOSURES that do not require consent:

- ***When disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement.*** For example, I may make a disclosure to applicable officials

when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.

- ***For public health activities***. As required by law, I may disclose your PHI to public health or legal authorities charged with preventing, controlling or responding to disease, injury, disability and/or death including child abuse and neglect.

- ***For health oversight activities***. For example, I may have to report information to assist the government when it conducts an investigation or inspection of a health provider or organization.
- ***To avoid harm***. To prevent a serious threat to your own health or safety or the health or safety of others.
- ***For workers' compensation purpose***. I may provide PHI in order to comply with workers' compensation laws.
- ***Appointment reminders and health related benefits or services.*** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

3. YOUR INDIVIDUAL RIGHTS REGARDING YOUR CHILD'S PHI

a. ***The Right to Choose How I Send PHI to You***. You have the right to ask that I send information to you at an alternate address or by alternate means (for example, e-mail instead of regular mail). I will agree to your request so long as it is reasonable for me to do so.

b. ***The Right to see and Get Copies of Your Child's PHI.*** In most cases you have the right to get copies of your PHI, but you must make the request in writing. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI collected in connection with a legal proceeding. I will respond to you within 10 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

c. **The *Right to Get a List of the Disclosures I have made***. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to such as those named for treatment, payment, or health care operations directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or disclosures made before June 1, 2008.

d. ***The right to ask that I limit how I use and disclose your Child's PHI***. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am " legally" required or allowed to make.

e. ***The Right to Correct or Update Your Child's PHI.*** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 30 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (a) Correct and complete, (b) not created by me, (c)

not allowed to be disclosed, and/or (d) not a part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it and tell others that need to know about the change to your PHI.

4. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES.** If you have any questions about this notice or any complaints about my privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services please contact your provider, Family Christian Counseling Center of Phoenix. There will not be any retaliation for filing a complaint.
5. **EFFECTIVE DATE OF THIS NOTICE**. This notice went into effect on June 1, 2008

**** Please sign the attached consent page. You may keep these three pages for your records.****

NOTICE OF PRIVACY PRACTICES SIGNATURE PAGE
CONSENT TO USE & DISCLOSE
PROTECTED HEALTH INFORMATION (PHI)

This form documents your consent with HIPAA laws regarding Protected Health Information (PHI) about your child. This information is necessary to provide treatment, to arrange payment for services, and for business activities ("Health Care Operations").

By signing this form, you agree to allow Family Christian Counseling Center of Phoenix to use this information and share it with others for treatment-related purposes. If this Notice changes, you will be notified at our next session. You may revoke your consent at any time after signing.

I hereby acknowledge that I have reviewed and received a copy of the "Notice of Privacy Practices" for the psychotherapy practice of Family Christian Counseling Center of Phoenix.

Print Name: _____

Signature: _____

Print Name: _____

Signature: _____

Date: _____

Permission for Animal Assisted Therapy (AAT)

_____has permission to visit with the approved therapy dogs at the Family Christian Counseling Center of Phoenix (FCCCP).

- Therapy dogs at FCCCP have passed the screening of Delta Society, an internationally recognized registrar of therapy animals.
- Therapy dogs will be regularly groomed and clean when visiting with clients.
- Therapy dogs will receive regular veterinary care, and are current on their shots.
- Generally recognized safety protocols for limiting the transmission of germs via the dog will be followed.

Confidentiality - (please refer to the HIPPA notice for additional information):

- The law requires that I report suspicions or evidence of child abuse, or child's/parent's expressed intention to harm oneself or others.
- Individuals may choose to contact me via email, fax or cell phone. In doing so, they agree to the understanding that email, fax and cell phone communication are not guaranteed confidential methods of communication.

Therapist Availability/Emergencies:

- To reach any of our therapists by phone, you can leave a message at **(602) 325-1233.**
- If your child is having a crisis or clinical emergency, **please call 911 or the EMPACT crisis line at 480-784-1500**. **This crisis line is available 24 hours a day, 7 days a week.** Please leave a message for your therapist as well.
- If your child is seeing a Psychiatrist, it is advised that you contact him/her in times of emergent need.

Consent to Treatment:

- Your signature below indicates that you have had the opportunity to read the information in this document and that your questions regarding your child's care have been satisfactorily answered.
- Furthermore, it indicates that you are a legal parent or guardian of _____ and that you **consent to treatment for your child.**
- It also indicates that you understand and give permission for your child's therapist to seek clinical supervision or consultation about client issues when necessary (while maintaining client anonymity).
- A copy of this document will be provided at your request.

Signature: _____Date_____

Parent/Guardian

Signature:_____Date_____

Parent/Guardian

Parent/Guardian Questionnaire

****Each parent should complete their own questionnaire****

Relationship to child: _____

My child's strengths are:

_____

_____

The 3 things that concern me the <u>MOST</u> are:

1. _____
2. _____
3. _____

What effect have these difficulties had on your child and your family? _____

_____

_____

What is the most challenging part of your relationship with your child?

_____

_____

I discipline my child in the following ways:

_____

_____

I want to improve my relationship with my child in the following ways:

_____

_____

The things I enjoy most about my relationship with my child are:

_____

_____

Therapist's Notes

The 3 GOALS that I have for my child's therapy are:

1. _____
2. _____
3. _____

I will know things are better when:

1. _____
2. _____
3. _____

Parent/Guardian signature: _____

Date_____

Therapist's Notes

For Office Use Only – Diagnosis code _____

Therapist name and credentials: _____

Signature: _____ Date: _____

Parent Signature_____ Date:_____

Parent/Guardian Questionnaire

****Each parent should complete their own questionnaire****

Relationship to child: _____

My child's strengths are:

_____

_____

The 3 things that concern me the <u>MOST</u> are:

1. _____
2. _____
3. _____

What effect have these difficulties had on your child and your family? _____

_____

_____

What is the most challenging part of your relationship with your child?

_____

_____

I discipline my child in the following ways:

_____

_____

I want to improve my relationship with my child in the following ways:

_____

_____

The things I enjoy most about my relationship with my child are:

_____

_____

Therapist's Notes

Therapist's Notes

The 3 GOALS that I have for my child's therapy are:

1. _____
2. _____
3. _____

I will know when things are better when:

1. _____
2. _____
3. _____

Parent/Guardian: Signature: _____

Date _____

Discussion of Goals and Methods

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

For Office Use Only – Diagnosis code _____

Therapist name and credentials: _____

Signature_____ Date:_____

Parent Signature_____ Date:_____

Family Christian Counseling Center
1300 E. Missouri, Phoenix AZ 85014
(602) 325-1233
www.familycccp.org

INTAKE QUESTIONNAIRE

Child's Name: _____DOB: _____Age: _____

Person completing form: _____

Briefly describe the main reason you are seeking help for your child:

_____

_____

When did you first become concerned about these problem(s)? _____

_____

_____

Therapist's Notes

Please list **all those living in your home** besides the child. This includes spouse, siblings, partner, friends and relatives. *Please use the back of this form if needed.*

Name	Age	Gender	Relationship to Child
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	

Separation/Divorce:

Are parents separated or divorced? ☐Yes ☐No If yes, for how long? _____
If parents are separated/divorced, does non-custodial parent share legal custody? ☐Yes ☐No
Are both parents aware that this child will be receiving counseling? ☐Yes ☐No
Does child have contact with both parents? ☐Yes ☐No How often?_____

Counseling History

Has your child previously received counseling? ☐Yes ☐No If yes, when and for what?
Do you think that it was a positive experience for your child? ☐Yes ☐No
Was it a positive experience for both parents? ☐Yes ☐No
Has your child received medication for behavior or moods? ☐Yes ☐No
If yes, what was the outcome?_____

Please complete the following questions:

How well does your child fall asleep, stay asleep and wake up from naps and in the morning**?**

_____

How does your child respond to separation? _____

What is your child's favorite thing to do? _____
Please describe a typical day in the life of your child: _____
_____
What is the most important thing that I can do for you today?
_____

Therapist's Notes

Medical History

Pediatric office: _____ Doctor: _____
Address: _____Phone: _____
Does your child have any **current** /**past** medical/physical concerns? ☐Yes ☐No
If yes please describe: _____

Has your child had any of the following? If yes, please explain:
Head injuries? ☐Yes ☐No If yes, did child lose consciousness? ☐Yes ☐No
Hospitalizations? ☐Yes ☐No_____
Surgeries? ☐Yes ☐ No _____
Medical procedures? ☐Yes ☐No _____
Seizures? ☐Yes ☐No _____
Serious illness ☐Yes ☐No _____
☐ hearing difficulties ☐ eye/vision problems ☐ asthma
☐ sensory problems (i.e. doesn't want to touch certain textures; bothered by bright lights)
☐ fine motor problems (handwriting, cutting, using fingers)
☐ gross motor problems (clumsy, poor balance, trouble running)
☐allergies (food, pet, etc) ☐Yes ☐No If yes, what? _____

Current Medications: please add additional information on back if needed.

Name of Medication	Dose/frequency	Reason	How long prescribed	Prescribing Doctor

Prenatal/Birth History

Did mother receive prenatal care? ☐Yes ☐No
Were there any complications during: Pregnancy ☐Yes ☐No _____
Labor ☐Yes ☐No _____
Delivery ☐Yes ☐No _____
Was child born premature or full-term? _____ Vaginal or Caesarian?
_____
Child's Weight at birth _____

Was there an extended hospital stay for mother/child after delivery? ☐ Yes ☐ No

_____

Did child spend any time in the NICU? ☐ Yes ☐ No _____

Alcohol or drug use during pregnancy? ☐ Yes ☐ No _____

Use of medication during pregnancy? ☐ Yes ☐ No _____

Did mother have post-partum depression? ☐ Yes ☐ No _____

Therapist's Notes

Family Christian Counseling Center
1300 E. Missouri, Phoenix AZ 85014
(602) 325-1233
www.familycccp.org

Child's Name:_____

Please check any items below that your child experienced as an <u>infant or toddler:</u>

- ☐ Exposure to lead
- ☐ Walking/gross motor delay
- ☐ Speech/Language delay
- ☐ Hand coordination/fine motor delay
- ☐ Poor attachment to parents/caregivers
- ☐ Sleeping difficulties
- ☐ Problems eating
- ☐ Not wanting touch
- ☐ Clingy
- ☐ Repetitive movements
- ☐ Difficult to comfort
- ☐ Eating non-foods
- ☐ Overly social/friendly
- ☐ Slow response when called by name
- ☐ Avoidance of eye contact
- ☐ Separation from parents
- ☐ Loss of previous abilities
- ☐ Other _____

Developmental Milestones: Please note any <u>delays or concerns</u> with following milestones:

Sitting	_____	First word	_____
Crawling	_____	Two-word sentences	_____
Standing	_____	Toilet trained	_____
Walking	_____	Imitates others	_____

Childcare

Childcare: _____Phone# _____
☐ center ☐ home daycare ☐ in your home ☐ before/after school
☐ friend/neighbor ☐ other_____
#Days/week:____ #hours/day: ___ # Children in facility:_____
Has child been asked to leave any childcare? ☐ no ☐yes

Education

School: _____Grade: _____ Teacher _____
Has your child attended other schools? ☐No ☐Yes : How many? _____
What prompted the change? _____
Overall, how is your child's academic progress? ☐ excellent ☐good ☐fair ☐poor ☐ struggling
Does your child receive any special services?
☐ tutoring (in school/ private) ☐ occupational/speech/physical therapy ☐ 504 plan ☐ IEP ☐ Other_____
Have you ever been called to pick your child up at school due to misbehavior? ☐ No ☐Yes ☐_____
Has your child ever had detention, been suspended or asked to leave a school? ☐ No ☐Yes ☐_____
_____
Does child ever report not liking school or teachers? ☐No ☐Yes
Child's Name: _____

Therapist's Notes

Child and Family History - Please indicate any that child has experienced:

- ☐ Parent injury/ illness/hospitalization
- ☐ Unemployment of family member
- ☐ Alcohol or drug abuse by family member
- ☐ Abuse (Sexual, emotional, verbal, physical)
- ☐ Violence in the home
- ☐ Violence in the community
- ☐ Family members have been arrested
- ☐ Family members have been incarcerated
- ☐ Police confrontation/arrest of Parent/guardian
- ☐ Death in the family
- ☐ Conflict between parents
- ☐ Witness to drug abuse
- ☐ Financial stress for caregiver
- ☐ Exposure to traumatic event
- ☐ Car accident
- ☐ Home robbery/invasion
- ☐ Disaster (natural/other)
- ☐ Frequent moves

Therapist's Notes

Family Mental Health History – *Family history is important to understanding your child's behavior and treatment. Please indicate below if anyone in the family has experienced the following.*

Has anyone experienced:	**Mother's Side**	**Father's Side**
Anxiety		
Depression		
Bipolar disorder		
Learning disorders (ADHD, dyslexia…)		
Drug abuse		
Alcohol abuse		
Schizophrenia		
Suicide attempts		
Completed suicide		
Panic Attacks		
Collecting useless items		
Violent temper		
Abuse (Physical/ Emotional/ Verbal / Sexual)		
Hallucinations or Delusions		
Strange behavior or thinking		
Other:		
Other:		

BEHAVIOR CHECKLIST: Please check items that describe your child's behavior for the **past year:**

□ Academic/homework problems	□ Not interested in things
□ Angry mood/Rages	□ Paying attention; focusing difficulties
□ Anxiety	□ Perfectionism
□ Arguing	□ Playing with fire
□ Being bullied or bullying	□ Repetitive habits
□ Blames others	□ Rigid routines
□ Bossiness	□ Unusual behavior
□ Confused thinking	□ Self injury
□ Crying frequently	□ Separation anxiety
□ Defiant (to parents or other adults)	□ Sexualized behavior that seems inappropriate
□ Destroys things	□ Shyness (excessive)
□ Disorganized, loses things	□ Sleeping, waking difficulties
□ Doesn't want to try new things	□ Somatic complaints (headaches/stomachaches)
□ Eating issues (too much, too little)	□ Stealing
□ Easily frustrated	□ Strong feelings of guilt or shame
□ Emotional outbursts	□ Suicide attempts
□ Fears	□ Suicidal thoughts (says wants to die)
□ Forgetfulness	□ Talking back
□ Frequent conflict	□ Tantrums
□ Grief/loss	□ Threats or comments about hurting self
□ Hair pulling	□ Threats or comments about hurting others
□ Hard to make/keep friends	□ Too concerned with neatness
□ Hears or sees things others do not	□ Toileting
□ Hits others	□ Transitions are difficult
□ Hurts animals	□ Strong reactions to textures, light, sound
□ Hyper; trouble sitting still	□ Unhappy, sad or depressed
□ Impulsive	□ Unusual thoughts
□ Irritable	□ Wetting/ soiling pants or bed
□ Lack of confidence	□ Withdrawn; not sociable
□ Learning and remembering problem	□ Worries a lot
□ Mood quickly goes up and down	□ Yelling
□ Nightmares/Night terrors	□ Won't speak outside the home

Therapist's Notes

Therapist _____**Date**_____