Cindi Stoneman, MA, LPC

*Registration Interview – **Child and Adolescent***

Counseling services for individuals, families, and groups.

CONFIDENTIALITY All information on this Registration Interview is confidential and will not be disclosed without your written authorization.

CLIENT INFORMATION - CHILD

Name:____ Date:________________
(Last) (First) (Initial)

Address: ____
(Street)

____
(City) (State) (Zip Code)

Client Birthdate:___________________________ **Social Security No**.:___________________________

Marital Status: ❑ Single ❑ Married No. of Children:__________ Name of Spouse:____________________

Date of Birth-Spouse:______________ Telephone (Home):____________________ TDD? ❑ Yes ❑ No

Message Telephone:______________________________ Message Source:____________________

Client Job Title:______________________________ Work Phone No.:____________________

Employer Name & Address:____

Person to Notify in case of emergency: ____________________________**Phone**: ________________

GUARANTOR

Who will be responsible for payment for services received?

Name:_______________________________________ Social Security No:____________________
(Last) (First) (Initial)

Relationship to Client:______________________________ Birthdate:____________________

Address:____
(Street)

____
(City) (State) (Zip Code)

Telephone: (Home)______________________________ (Work)___________________________

INSURANCE INFORMATION

Primary Insurance Provider:

Name of Company:____

Policy No.:____________________________________ Group No.:_________________________

Phone No.:____

Address:________________________________ City__________State_________ Zip__________

REFERRAL INFORMATION

Who sent you to this office? How did you hear about my services?

Name or Place:____

PURPOSE & GOALS

1) What is your reason for coming to counseling?

____

____

____

____

2) What are your goals for counseling and what do you want to accomplish?

____

____

____

____

3) What are your **strengths**? ____

____

REGISTRATION INTERVIEW

PERSONAL INFORMATION

How old are you? _______________

Siblings (brother or sister) name	**M**ale or **F**emale	Age	Date of Birth

What is your educational (school) history?
(Please list name of school, city & state school is located, year you graduated or how long attended)

Grammar School:______________________________

High School:______________________________

College or Technical School:______________________________

What is your work history (if any)?

Company | City & State of Company | Year

____

____

____

____

____

COMMUNICATION ABILITIES

Do you prefer to communicate in
❑ English? ❑ Spanish? ❑ Sign Language? ❑ Other?______________________

Do you use Hearing aids? ❑ Yes ❑ No If Yes, ❑ left ear? ❑ right ear? ❑ in-the-ear? ❑ over-the-ear?

If you are deaf or have a hearing impairment, what is the degree of your loss?
right ear?______________________ left ear?____________________

When did your hearing loss first occur and how old were you?

____

What was the reason for your hearing loss?

____

Do you have a family history of deafness? ❑ Yes ❑ No

If yes, what was their relationship to you? ______________________________

MEDICAL INFORMATION

Do you have any medical or physical problems or limitations? (Example: heart, back problems, vision)

____

____

Are you under a doctor's care? ❑ Yes ❑ No
If yes, please explain:____

Who is your doctor? Name:____

Address:_______________________________________Telephone:____________________

Are you taking any prescription medications? ❑ Yes ❑ No

Name of **Prescription** Medication(s)	Dosage	Taken Since

Do you take any ***over-the-counter drugs/medications***? ❑ Yes ❑ No

Name of **Over-The-Counter** Medication(s)	Dosage	Taken Since

PRIOR TREATMENT

Have you ever had any psychological counseling? ❑ Yes ❑ No

Name:___________________________________ Telephone:______________________________

Have you ever had any psychiatric care? ❑ Yes ❑ No

Doctor's Name:______________________________ Telephone:__________________________

What were your reasons for treatment or counseling? ______________________________________

____

Presenting Problem ______________________________

____

____

When did it start? ❑ Less than 1 wk ❑ Less than 1 mo ❑ Less than 6 mo ❑ 6 mo to 1 year ❑ More than 1 year
❑ Other ______________________________

How often does it occur? ❑ Several times an hour ❑ Several times a day ❑ Daily ❑Weekly ❑Bi-weekly
❑ Other ______________________________

When is it better? ❑ Morning ❑ Afternoon ❑ Evening ❑ Weekdays ❑ Weekends
❑ Person (who ______________________________) ❑ Situation (what ______________________________)
❑ Other ______________________________

When doesn't it happen? ______________________________

Who is most affected by it? ❑ Mom ❑ Dad ❑ Step Parent ❑ Siblings ❑ School ❑ Peers ❑ Client
Other ______________________________

How have you tried to solve it? ❑ Time Out ❑ Spanking ❑ Medications ❑ Reward ❑ Removing Privileges ❑ Grounding
❑ Other ______________________________

What makes it worse? ______________________________

How will you know if it is better? ______________________________

Family Situation

Live with: ❑ Natural Parents ❑ Mother ❑ Father ❑ SM/SF ❑ Sibling ______________ ❑ Other ______________

Is child adopted? ❑ No ❑ Yes If yes, at what age? ______________ Does child know of adoption? ❑ No ❑ Yes

Quality of family relationships

Client & Mother	❑ Good	❑ Problematic	______________________________
Client & Father	❑ Good	❑ Problematic	______________________________
Client & Sibling(s)	❑ Good	❑ Problematic	______________________________
Sibling(s) & Parents	❑ Good	❑ Problematic	______________________________
Marital	❑ Good	❑ Problematic	______________________________
Other	❑ Good	❑ Problematic	______________________________

Marital History of Parents

How long married? ______________________ Are parents currently in custody/visitation dispute? ❑ No ❑ Yes

Custody Arrangement: ❑ N/A ❑ Joint ❑ Sole(M) ❑ Sole (F) ❑ Shared

REGISTRATION INTERVIEW

Family history ❑ N/A

❑ Drugs/ETOH	
❑ ADHD	
❑ Depression	
❑ Learning Problems	
❑ Behavior Problems	
❑ Psychotic Disorders	
❑ Mental Illness	
❑ Other	

Developmental History

Pregnancy: ❑ WNL(within normal limits) ❑ Planned ❑ Unplanned ❑ Problems (describe) ____________________________

Mother used: ❑ Alcohol ❑ Cigarettes ❑ Other drugs/medications ____

Delivery: ❑ Full Term ❑ Early ❑ Late ❑ Complications ____ Wt.:___lbs.___oz.

Physical/Motor Development: ❑ WNL ❑ Delayed (describe) ____

Speech/Lang Development: ❑ WNL ❑ Delayed (describe) ____

Social/Emotional Development: ❑ WNL ❑ Delayed (describe) ____

Temperament (Early Childhood):

Activity Level	❑ High	❑ WNL	❑ Low
Distractibility	❑ High	❑ WNL	❑ Low
Attention Span	❑ High	❑ WNL	❑ Low
Feeding	❑ Easy	❑ WNL	❑ Difficult
Mood	❑ Easy Going	❑ WNL	❑ Difficulty
Mood Intensity	❑ High	❑ WNL	❑ Low
Response to new stimuli	❑ Approachable	❑ WNL	❑ Avoidant
Adaptability to change	❑ Flexible	❑ WNL	❑ Rigid

Changes in temperament over time (described) ____

Other Significant Information ____

____

Education History

Significant problems/concerns or recent changes ____

____

____

Current Grade __________ School ______________________________ Teacher's Name _____________________________________

Check any that apply:

❑ LD ❑ Special Ed (explain) _________________________________ ❑ Retained (explain) _________________________________

❑ Attendance problems (explain) ____

Peer Relationships

Significant problems/concerns with peers/recent changes ______________________________

____

____

Friendship patterns/connectiveness: ❑ Leader ❑ Follower ❑ Isolates ❑ Easily Influenced ❑ Outgoing ❑ Appropriate

Ability to initiate friendships: ❑ Good ❑ Fair ❑ Poor

Socialization with peers: ❑ Not active ❑ Active ❑ Over-involved

Quality of friendships: ❑ Good ❑ Fair ❑ Poor Gang related behaviors: ❑ No ❑ Yes

Do friends use alcohol or drugs? ❑ No ❑ Yes – Is this a problem? ❑ No ❑ Yes

Average number of friends ______________ Recent losses in peer relations ______________

Other feedback about peer relationships ______________________________

Dating ❑ N/A

Currently involved in a dating relationship? ❑ No ❑ Yes

Last dating relationship - length ______________

Specific problems in dating relationships (describe) ______________________________

Sexually active: ❑ No ❑ Yes – Are parents aware? ❑ No ❑ Yes Protection used? ❑ No ❑ Yes

Sexual concerns (birth control, pregnancy, etc.): ______________________________

Substance Abuse History ❑ N/A

(Alcohol, street drugs, OTC, inhalants, cigarettes/tobacco)

Drugs Used	Age of First Use	Frequency/Quantity Route of Administration	Last Use

Potential legal consequences of use: ❑ Arrests ❑ Criminal behavior ❑ Stealing ❑ Selling drugs ❑ Unprotected sex

Social consequences of use: ❑ change in peer group association ❑ Withdrawal from/problems with family
❑ Friends ❑ Skipping school ❑ Missed work

Have other people indicated they think child has an alcohol/drug problem? ❑ No ❑ Yes

Does the child think they have an alcohol/drug problem? ❑ No ❑ Yes

Other significant information: ______________________________

____

REGISTRATION INTERVIEW

SIGNATURE PAGE

___ itial CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a **minimum of 24 hours notice is required for re-scheduling or canceling an appointment.** Unless we reach a different agreement, a fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions, therefore payment of this fee is the responsibility of the client.

I/we have read the document entitled Agreement/Informed Consent for Psychotherapy Services and Office Policies and General Information carefully; have had the opportunity to ask questions; understand the agreement, policies, and information; agree to comply with them; and agree to begin treatment:

X ______________________________

Client/parent/guardian (print) Date Signature

____

Client/parent/guardian (print) Date Signature

For office use only - Verification that client/parent/guardian has read the document entitled Agreement/Informed Consent for Psychotherapy Services and Office Policies and General Information, had the opportunity to ask questions, understands the agreement, policies, and information, agrees to comply with them, and agrees to begin treatment.

Cindi Stoneman MA, LPC, NCC:______________________ Date: ______________

I/we acknowledge receipt of the HIPAA Notice of Privacy Practices and have read and understand my rights:

X ______________________________

Client/parent/guardian (print) Date Signature

____

Client/parent/guardian (print) Date Signature

REGISTRATION INTERVIEW

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise the Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of the Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

X
____
Client/parent/guardian (print)   Date   Signature

____
Client/parent/guardian (print)   Date   Signature