Client Information – Adolescent

Teen's name: ____Today's date: ___/___/_____

Address: ____
(Street) (City) (State) (Zip)

Date of birth: ___/___/____ Age: _____ Grade and School__________________________________

Gender: ______________ Sexual orientation: ________________ Preferred pronouns: _________________

PARENT / GUARDIAN 1

Parent 1 Name: ____

Please circle all that apply: Biological parent Foster parent Grandparent Step-parent Legal guardian

Do you have legal custody? ☐Yes ☐No If no, who does?_________________________________

Do you have physical custody? ☐Yes ☐No If yes, please list the days and times that your child lives with parent 1 ____

Address: ____
(Street) (City) (State) (Zip)

Date of birth: ___/___/_____ Gender: ________________ Sexual orientation________________

Occupation: ___________________________________ Employer: ______________________________

Phone: ____________________ (home) ___________________ (work) _____________________ (mobile)

Email: ______________________________________

OK to send snail mail? ☐Yes ☐No OK to email? ☐Yes ☐No

OK to call? ☐Yes ☐No OK to leave message? ☐Yes ☐No Preferred number? _________________

Please provide a name and phone number in case of emergency: ________________________________
____

PARENT / GUARDIAN 2

Parent 2 Name: ____

Please circle all that apply: Biological parent Foster parent Grandparent Step-parent Legal guardian

Do you have legal custody? ☐Yes ☐No If no, who does? _________________________________

Do you have physical custody? ☐Yes ☐No If yes, please list the days and times that your child lives with parent 2 ____

Address: ____
(Street) (City) (State) (Zip)

Date of birth: ___/___/_____ Gender: ________________ Sexual orientation________________

Occupation: ______________________________________ Employer: ______________ ________________________

Phone: ______________________ (home) _____________________ (work) ________________________ (mobile)

Email: ____

OK to send snail mail? ☐Yes ☐No OK to email? ☐Yes ☐No
OK to call? ☐Yes ☐No OK to leave message? ☐Yes ☐No Preferred number? __________________

Please provide a name and phone number in case of emergency: ___________________________________
____

PAYMENT INFORMATION
Private/Self Pay: ☐Yes ☐No

If you are using insurance (circle one): Health New England or Blue Cross Blue Shield

***You are ultimately responsible for payment of any charges incurred, regardless of whether your insurance honors this claim. Please call your insurance company before your first appointment to clarify your benefits.**

Signature indicating that you understand and agree to this payment arrangement:___________________

Co-pay or coinsurance (this should be on the front of your card): $_________________

Name of Policy Holder: ____

Birth Date of Policy Holder: ____

Address of Policy Holder: ____

Insurance ID Number of Policy Holder: ____

FAMILY INFORMATION
Parent 1 - Who currently lives with you in your home or is a part of your immediate family?
Name Age Relationship (i.e., spouse, partner, sibling, etc.)
____
____
____
____

Parent 2 - Who currently lives with you in your home or is a part of your immediate family?

Name | Age | Relationship (i.e., spouse, partner, sibling, etc.)

____
____
____
____

Current reason(s) for seeking therapy: ____
____
____

Has your teen or any other family member struggled with any of the following problems?

	Child - Current	Child - Past	Parent 1	Parent 2	Sibling	Other
Depression/sadness						
Anxiety/Panic attacks						
Learning disabilities						
Obsessions/compulsions						
Suicidal thoughts						
Attempted suicide						
Gender dysphoria						
ADD / ADHD						
Anger problems						
Defiance/oppositional						
Schizophrenia						
Bipolar disorder						
Drug abuse						
Eating disorder						
Physical or Sexual abuse						
Alcohol abuse						
Self-injury (purposeful)						
Hospitalized (psychiatric)						
Other:						

STRESSORS

Has your family experienced any of the following in the past year?

☐ Serious illness or injury of loved one ☐ Serious illness or injury of a child
☐ Change in job/new position/new hours ☐ Change in financial status
☐ Death in the family ☐ Death of a close friend
☐ Family fighting ☐ Domestic violence ☐ Conflict with in-laws
☐ Marital problems ☐ Divorce or separation ☐ Marital reconciliation
☐ Move to new home ☐ Problems with parenting
☐Other (please describe): ____

HEALTH INFORMATION

Name of your teen's medical doctor: ____

Address of medical group:____Phone:______________

Name of psychiatrist/prescriber:_______________________________________Phone:______________

Address of psychiatrist/prescriber:____________________________________Phone:______________

Has your child ever been hospitalized? (if yes, please provide details):____________________________

____

Is your teen currently taking any prescribed medications? (Please list names, dosages, frequency and prescriber):____

____

Please list any current health concerns:____

Hs your teen previously participated in therapy or counseling? ☐Yes ☐No

Therapist name | Location (City/State) | Dates

____

____

Was it helpful ☐Yes ☐No Why or why not?____

OTHER

Is there anything else that you would like me to know? ____

____

____

____

____

Consent for Psychotherapy and Terms of the Agreement Signature Page

By signing below, the client (or child's parent/guardian) acknowledges that s/he has reviewed and fully understands the terms and conditions of this agreement.

The client has discussed the terms and conditions with the therapist and has had the opportunity to have any questions with regard to its terms and conditions answered to client's satisfaction. Client (or child's parent/guardian) agrees to abide by the terms and conditions of this agreement and consents to participate in psychotherapy with Amy Gray, LICSW.

Moreover, client (or child's parent/guardian) agrees to hold Amy Gray, LICSW free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Name of Client (print):____

Signature of Client (if over 18 years of age):____

Signature of Parent/Guardian (if under 18 years of age): _____________________________________

Date: ________________

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION SIGNATURE PAGE

This form is an agreement between the child's legal guardian_______________________________ and Amy Gray, LICSW. When we use the word "you" below it will mean your child/adolescent.

When I assess, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment with insurance companies or for other business or government functions**.**

By signing this form you are agreeing that you have read and understand my Notice of Privacy Policies and you are agreeing to allow me to use your information and to send it to others in accordance with our written policies. Please make sure you have read and understand my Privacy Policies above before signing this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Policies, I cannot work with you.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on.

Name of Client (print):____

Signature of Parent/Legal Guardian (if under 18 years of age): ________________________________

Date: ________________