CHILD PROBLEM SCREENING FORM

Child's name: _____Child's date of birth:_____ Age: _____

Rater's name: _____ Relationship to Child: _____
Today's date:_____

Directions: Below is a list of ways that children may act, think, or feel. Please (1) circle the number showing how often your child has behaved this way in the past 3 months and (2) circle "Yes" if it is currently a problem or "No" if it is not a problem. How Often Does This Occur?

	Never, Seldom, Sometimes, Often, Always					Is This A Problem Now?	
Argues with others	1	2	3	4	5	Yes	No
Can't concentrate/pay attention	1	2	3	4	5	Yes	No
Acts sad or depressed	1	2	3	4	5	Yes	No
Feeding/eating problems	1	2	3	4	5	Yes	No
Teases or fights with others	1	2	3	4	5	Yes	No
Is teased	1	2	3	4	5	Yes	No
Appears lonely	1	2	3	4	5	Yes	No
Can't sit still/hyperactive	1	2	3	4	5	Yes	No
Too fearful or anxious	1	2	3	4	5	Yes	No
Disobeys at home	1	2	3	4	5	Yes	No
Disobeys at school	1	2	3	4	5	Yes	No
Moody	1	2	3	4	5	Yes	No
School Academic Problems	1	2	3	4	5	Yes	No

	Never, Seldom, Sometimes, Often, Always					Is This A Problem Now?	
Temper tantrums/hot temper	1	2	3	4	5	Yes	No
Impulsive/acts without thinking	1	2	3	4	5	Yes	No
Threatens/tries to hurt others	1	2	3	4	5	Yes	No
Low self-esteem	1	2	3	4	5	Yes	No
Toilet problems/wetting/soiling	1	2	3	4	5	Yes	No
Self-conscious/embarrassed	1	2	3	4	5	Yes	No
Perfectionistic	1	2	3	4	5	Yes	No
Threatens/tries to hurt animals	1	2	3	4	5	Yes	No
Threatens/tries to hurt self	1	2	3	4	5	Yes	No

Any other Characteristics that you are concerned with?

_____

_____

_____

Look back over the concerns you have identified and choose the one that you most want your child helped with. Which is it? _____

_____

Jena D. McNamar, MAMFT, LPC, PLLC
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GENERAL CONSENT FOR TREATMENT FOR CHILDREN AND ADOLESCENTS

_____Client's Name _____Therapist's Name

1. All clinic files are confidential and my written consent is required for any release of information by the clinic to any other persons outside the clinic except in the following circumstances: (a) court orders and subpoenas, (b) to defend legal action against the clinic, (c) need to prevent clients from harming him/herself or others, and (d) suspected child abuse/neglect. If you request that the clinic submit reimbursement forms for your insurance, complete confidentiality cannot be agreed. If you file a lawsuit related to mental health issues, clinic records may also be accessed by the court.

2. Your child's willingness and ability to use counseling depend a great deal on the confidentiality he/she is allowed to maintain in the therapeutic setting. While I have the right to access my child's file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my child's therapist about any questions I have concerning the content of my child's file or sessions.

3. I may be asked to sign consent forms for the release of social, medical, and/or psychological information from other agencies or individuals for the use by the staff of this clinic in my child's/my own assessment or treatment. I may request restrictions on the use/disclosure of information in my child's file for treatment, payment and health care operations purposes, but the therapist is not bound to agree with my request.

4. I understand that it is impossible to assure privacy of any communication by electronic means (email, text or faxes). Email or text message should never be used to communicate any urgent matter to the clinic.

5. Information from clients' files may be compiled to study various issues such as treatment outcomes and client satisfaction. My child's name or any identifying information will not be used in such research.

6. The clinic is open Monday through Saturday. My therapist and I will set appointments. For after-hours emergencies, I should call 911.

7. The practice of psychology and related disciplines is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of treatments, assessments, and consultations. I understand that I am responsible for working with my child's therapist to help ensure better treatment outcomes.

8. Jena D. McNamar is not a medical doctor; therefore she does not prescribe medications and is not authorized to practice medicine. If Jena D. McNamar thinks that my child should consider medication as a part of treatment, and I want to try this, Jena will refer us to a physician with whom he would work to provide coordinated services. I understand that psychological problems can have medical or biological origins and my child should have regular physical exams and speak with the doctor about all his/her symptoms.

9. I consent for myself and/or my child to undergo all testing and treatment procedures necessary to address the problems for which I am seeking help. I understand that I have the right to be informed of the nature and purpose of any procedure and that I can refuse or discontinue testing or treatment at any time.

10. I understand I am responsible for any fees for services to which I consent, and that failing to pay such fees may result in the termination of any further services to me. Payment is due at the beginning of my appointment. I must cancel at least 24 hours before my session, unless my therapist and I both agree my cancellation was due to an emergency, or I am responsible for the session fee before I can schedule a new session. Continued non-payment of fees may result in action including being referred to a collection agency.

11. I understand that special arrangements may need to be made regarding payment and reporting of assessment and treatment results in cases of divorce, foster care, and court mandated services.

PARENT QUESTIONNAIRE

Date _____Form Completed by _____ Relation to Child _____
Child's Name _____ M__ F __ Birthdate _____ Ethnicity _____
Address _____ Home Phone
_____ Work Phone (mother) _____ (father) _____
Child's Primary Physician _____Physician Phone _____
Insurance Company_____ Insurance through_____ Who referred the child?
_____ Address _____

FAMILY
Father's Name _____Birthdate _____ Address (if different from above) _____ Occupation
_____ Educational level _____ # of dependents _____ Mother's Name
_____Birthdate _____ Address (if different from above)
_____

Occupations_____ Education_____

# of dependents _____ Date of Marriage _____ Present Marital Status _____ If parents divorced, who has custody? _____ (Provide court order)

With whom does the child live? Birth parents_____ Adoptive Parents
_____ Foster Parents _____ Other (specify) _____
List all other persons living in the home: Name _____ _____
_____ _____ _____
List any other people who care for the child a significant amount of time:
Name _____ _____ Relationship to Child
_____ _____ Relationship to child (grandmother, neighbor, etc.)
_____
_____ Age _____
CHILD Pregnancy and Birth: Any Complications? _____ If yes, briefly explain
_____ _____ At what age did your child: Sit Without Support _____ Walk _____ Begin Talking _____ Stay Dry Through the Night ____ Has your child had any medical complications? _____ If yes, briefly explain _____
_____
Please list any jobs or chores your child has at home or school (e.g., feeding the dog, making the bed, safety patrol) _____
How well does your child do these chores? _____
What are your child's strengths? _____
How many close friends does your child have? _____
How many times a week does your child do things with them? _____

How many friends in the neighborhood does your child have? None ___1___2___3 ___4 + ____
Compared to other children his/her age, how well does your child get along with other children?

Poor Average Great
1 2 3 4 5

What are your child's favorite play or after school activities? _____

FAMILY AND PERSONAL HEALTH HISTORY

Date of Last Physical Examination _____ Child's Height _____ Child's Weight _____
Check condition and relationship of any blood relative who has or has had any of the conditions listed below :

Alcoholism/Substance Abuse _____
Allergies _____ Birth Defects _____
Cancer _____ Colitis _____
Depression _____ Heart Attack _____
High Blood Pressure _____ Migraine _____
Mental Illness _____ Seizure Disorder _____
Mental Retardation _____ Learning/Attention Problems_____
Suicide/Suicide Attempt _____
Other (Specify) _____

DISCIPLINARY STRATEGIES Who generally disciplines the child?

_____
What methods are used? _____
Are these methods effective? _____
Do parents agree on methods of discipline? _____ Elaborate, if no_____
_____

SCHOOL HISTORY

Child being seen _____
Father _____
Mother _____
Siblings _____

Has child been enrolled in nursery or day care? _____At what age? _____ Has child attended kindergarten? _____At what age? _____ Has child begun elementary school? _____ At what age? _____ Present grade and school _____ Does not go to school_____ If your child has ever been to school (including nursery, kindergarten and grade school). Complete the following for all classes beginning with nursery and ending with current placement. Please indicate if your child is in a special class (gifted, learning disabled, emotionally handicapped, etc.

_____, _____.

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CONSENT FOR TREATMENT SIGNATURE PAGE FOR CHILDREN AND ADOLESCENTS

Client's Initials

Therapy sessions and file information are confidential. _____
Except in cases of: (a) court orders/subpoenas, (b) to defend legal action against the therapist, (c) need to prevent harm to self or others, and (d) suspected child abuse/neglect.

Third party billing and lawsuits I bring related to mental health issues may also limit the confidentiality of my child's file. There are some limitations to my access to my child's file. _____

I understand that confidentiality is very important to my child's ability to use therapy.
While I have the right to access my child's file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my child's therapist about any questions I have concerning the content of my child's file or sessions. I must sign release forms before information can be exchanged with other agencies. _____

The privacy of any electronic communication cannot be assured. Do not use email for urgent matters. I may request restrictions on the use/disclosure of information in my child's chart for treatment, payment and health care operations, but the therapist is not bound to agree with my request. Some information from my child's file may be used in research. _____

I understand that names or any other identifying information will not be used in research. _____

Jena D. McNamar does not provide after-hours or emergency services
(use 911 for after-hours crises). Contact 911 or go to ER. _____

The practice of psychology and related disciplines is not an exact science. _____
No guarantees have been made to me regarding the results of Jena D. McNamar's services. We are responsible for working with our therapist to help ensure better treatment outcomes.

Jena McNamar is not a medical doctor and cannot prescribe medications. I consent to undergo all recommended testing and treatment procedures. _____

I can refuse or discontinue testing or treatment for myself or my child at any time. I agree to pay my clinic bill. Payment is due at the beginning of sessions and I must cancel at least 24 hours before my session or I am responsible for the cost of the session. _____

Client's Initials

Consequences of non-payment may include termination of services or being referred to a collection agency. Special payment/reporting arrangements may be made in cases of divorce, foster care, litigation and court- mandated services. _____

I acknowledge that my therapist has reviewed the General Consent for Treatment with me and I have been given a copy to keep for my own records. _____

_____ Signature of Therapist or Witness Date: _____

_____Signature of Guardian/Legal Representative

_____Printed Name of Guardian/Legal Represent