Gracelight Counseling Center – Linda Roberts, LPC
2216 Shadowlake Drive — Phone: 405-694-5233
Oklahoma City, OK 73159 — www.gracelightcounseling.com

Parent Questionnaire

Date _________ Form Completed by_________________ Relation to Child__________

Child's name ______________________M__F __ Date of birth ___________ Age _______

Home street address ____Apt.___________

City: _______________________________________ **State**: _________ **Zip**: _____________

Mother's phone: __________________ **Father's Phone**: _____________________________

Child's Primary Physician ________________________ Physician's Phone____________

Insurance Company____________________ Insurance primary person________________

Who referred the child? ______________________ Phone: ________________________

May I have your permission to thank this person for the referral? Yes No Initial ________

FAMILY

Father's name: _____________________________ **Birthdate**: _______________________

Address (if different from above) ____

Occupation: ___________________________________**Educational level_______________**

# of dependents ___________

Mother's name: _____________________________ **Birthdate**: ________________________

Address (if different from above) ____

Occupation: ___________________________________**Educational level_______________**

# of dependents ___________

Date of Marriage _________Present Marital Status ____If divorced who has custody____
(Provide court order)

With whom does the child live? Birth parents_____________________________________

Adoptive Parents______________________ Foster parents_________________________

List all other persons living in the home:

_____________________________ _____________________________

_____________________________ _____________________________

List any other people who care for the child a significant amount of time

Name ________________________

Relationship to Child (grandmother, neighbor, etc.) ____________________ Age _____

<u>CHILD</u>

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? ______________________

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?
__________________________________ __________________

<u>FAMILY AND PERSONAL HEALTH HISTORY</u>

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

Father ____________________________Paternal grandfather ________________________

Paternal grandmother _______________Paternal aunt/ uncle ________________________

Mother ____________________________Maternal grandfather _______________________

Maternal grandmother _______________Maternal aunt/uncle ________________________

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.)

School ______________________ ______________________ ______________________
Comments Regarding Behavior/Adjustment
____
____

Current School Performance (for children aged 6 and older)

Indicate if failing, below average, average, above average, excelling

(History/Geography, etc.) ____________________ Writing ______________________

Arithmetic or Math ___________________________ Spelling _______________________

Other Academic Subjects (science, foreign language, etc) __________________

PARENTAL CONCERNS

What do you feel is your child's main problem?

____

____

____

What do you feel caused your child's problem?

____

____

____

What have you been told by doctors, teachers, and/or others about your child's problems?

____

____

____

Has this child had any other mental health evaluations or treatment?

____

____

____

Has any member of the child's immediate family had mental health treatment?

____

____

____

Other comments

____

____

____

May we contact the child's primary physician?

To receive information _____________ To give information _______________________

____

(Signed) Parent or Guardian

Agreement to Pay for Professional Services

I, the client (or guardian/legal representative), request that Linda Roberts, LPC, provide professional services to ____________________, who is my ___________, and I agree to pay this therapist's fee of $ ________ per 45/50 minute session. This same fee will be applied per each hour of consultation, assessment, or other therapeutic activity unless otherwise negotiated in writing. Fees for legal issues may be substantially different and should be clarified.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform her, in person or by certified mail that I wish to end it.
I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I understand that if I do not pay for services that the services provided may be terminated by the therapist. Continued non-payment of fees may result in further consequences such as my case being referred to a collection agency.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. If my any part of my fees is being paid by an insurance company or other third-party payer, I understand that this may result in limitations to my confidentiality.

____ _________________
Signature of client (or person acting for client)   Date

____
Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____ _________________
Signature of therapist   Date

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CONSENT FOR TREATMENT 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 Gracelight Counseling Center or 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 others.
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 file 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 any identifying information will not be used in research. _____

Gracelight Counseling Center and Linda Roberts do not provide after-hours or emergency services (Contact 911 or go to the ER for after-hours crises). _____

The practice of psychology and related disciplines is not an exact science.
No guarantees have been made to me regarding the results of Linda Robert's services. I am responsible for working with my therapist to help ensure better treatment outcomes. _____

Linda Roberts 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 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.
Consequences of non-payment may include termination of services or being referred to a collection agency. _____

I acknowledge that my therapist has reviewed the General Consent for Treatment with me.

________________________	________________________	________________________
Signature of Therapist	Signature of Guardian/Legal Rep.	Signature of Child or Adolescent

Date: ____________________ Date: ______________

CONFIDENTIAL

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Notice of Privacy Practices

This notice talks about **privacy information**. We've always taken great care to safeguard your privacy. What is new is a government regulation requiring us to explain your rights. This notice describes how mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. In the event that the notice is changed, a new notice will be sent to you by mail or at the time of your next appointment. You may request a copy of our Notice at any time. This takes effect January 2011, and will remain in effect until we replace it.

Uses and Disclosures of Protected Health Information
You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment by signing the consent form, this agency will use or disclose your protected health information as described below.

- **Treatment:** We may use and disclose, as needed, your protected health information to provide, coordinate, or manage your health care and any related services.
- **Health Operations:** We may use and disclose, as needed, your health information in connection with our operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental healthcare professionals, evaluating practitioner and provider performance, employee review activities, conducting training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization:
Will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the notice.

- **Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Other permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to object
We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required by Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Health Oversight:** We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- **Abuse or Neglect:** We may disclose your protected health information to the Department of Human Services which is authorized by law to receive reports of child abuse or neglect. In addition,

we may disclose your protected health information if we believe that you have been a victim of abuse or neglect to the Department of Human Services.

- **Legal Proceedings:** We may disclose your protected health information in the course of any judicial proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

Client Rights - Access: You have the right to inspect and copy your protected health information. We will use the format you request unless we cannot practicably do so. You must submit your request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $1.00 for the first page, and $.25 each page thereafter to locate and copy your health information plus postage if you want the copies mailed to you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Restriction: You have the right to request restriction of your protected health information. You may also request that any part of your protected health information not be disclosed by family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If we agree to the additional restrictions we will be able to abide by our agreement (except in an emergency). We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted.

Amendment Request: You have the right to request that we amend your protected health information. Your request must be in writing and explain why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for you amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment or healthcare operations as described in this Notice of Privacy Practices.

Questions and Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We support your right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

I have read and understand Gracelight Counseling Center's Notice of Privacy Policy.

Client's
signature______________________________Date____

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?					Is This A Problem Now?
	Never	Seldom	Sometimes	Often	Always	
Argues with others	1	2	3	4	5	Yes No
Can't concentrate/pay attention	1	2	3	4	5	
Acts sad or depressed	1	2	3	4	5	
Feeding/eating problems	1	2	3	4	5	
Teases or fights with others	1	2	3	4	5	
Is teased	1	2	3	4	5	
Appears lonely	1	2	3	4	5	
Can't sit still/hyperactive	1	2	3	4	5	
Too fearful or anxious	1	2	3	4	5	
Disobeys at home	1	2	3	4	5	
Disobeys at school	1	2	3	4	5	
Moody	1	2	3	4	5	
School Academic Problems	1	2	3	4	5	
Temper tantrums/hot temper	1	2	3	4	5	
Impulsive/acts without thinking	1	2	3	4	5	
Threatens/tries to hurt others	1	2	3	4	5	
Low self esteem	1	2	3	4	5	
Toilet problems/wetting/soiling	1	2	3	4	5	
self-conscious/embarrassed	1	2	3	4	5	
Perfectionistic	1	2	3	4	5	
Threatens/tries to hurt animals	1	2	3	4	5	
Threatens/tries to hurt self	1	2	3	4	5	

Licensed Behavioral Practitioners **Licensure Marital and Family Therapists** **Licensed Professional Counselors**	**State Board of Behavioral Health** **3815 N. Santa Fe, Ste. 110** **Oklahoma City, OK 73118** **Telephone: (405) 522-3696** **Fax: (405) 522-3691** **www.ok.gov/behavioralhealth**

STATEMENT OF PROFESSIONAL DISCLOSURE

Please check the appropriate license: **XX LPC ❑ LBP**

I am required by law to furnish this document to you. It requires that I inform you about my professional training, orientation /techniques, experience, fees and credentials. I am licensed to practice my profession by the State Board of Behavioral Health Licensure.

My license number is **LPC______6216___________________**

The licensing website is **www.ok.gov/behavioralhealth** where you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact (without giving your name), the State Board of Behavioral Health Licensure at:

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
www.ok.gov/behavioralhealth

Licensee's Printed Name: Linda Roberts______________

Licensee's Signature: __________________________________Date: ________________

The above-designated licensee has satisfactorily supplied me with information regarding his/her practice, licensure and professional development.

Client's Signature:____________________________________