TREASURE WELLNESS COUNSELING AND TRAINING CENTER
2176 E. FRANKLIN ROAD, SUITE 100
MERIDIAN, IDAHO 83642
208-515-7661
WWW.TREASUREWELLNESS.COM

MINOR CLIENT INFORMATION

Please answer all information as completely as possible. Information will be managed as protected health information. If you need assistance, please ask. Your Counselor will review this information with you.

Client: ______________________________ Date: ____________________
Last First

Address: ____
Street City State Zip

Home Phone:_______________ Cell Phone:_________________ Work Phone: _______________

May we leave message: YES ☐ NO ☐ **May we leave message: YES ☐ NO ☐** **May we leave message: YES ☐ NO ☐**

Appointment Reminders: YES ☐ NO ☐ **Appointment Reminders: YES ☐ NO ☐** **Appointment Reminders: YES ☐ NO ☐**

Best Phone to Contact you at ☐ Home ☐ Cell ☐ Work Best Time: ______________________

Email Contact:_________________________________May we contact you by email: ☐YES ☐NO

Gender: _________ DOB: _________ Age: _____ Race/Culture: __________ Occupation: __________

EMERGENCY CONTACT: ____
Name Relationship Phone

PARENT/GUARDIAN INFORMATION

☐Single ☐Living with Partner ☐Married ☐Separated ☐Divorced ☐Widowed Length of Time: ________

PRESENT FAMILY

Please identify the family you currently live with and nature of your relationship with each member. Including yourself, list the members of your current family from oldest to youngest. Use back if needed.

Name	Relationship	Age	Currently this relationship is ... *i.e. good, neutral, conflictual etc.*

How did you find me? ☐ **Referral If so, Who?** ______________________________

☐ **Web Search** ☐ **Psychology Today** ☐ **Website** ☐ **Other:** ______________________

HEALTH INFORMATION

Primary Care Physician: ☐ Y ☐ N Name: ____________________________ Phone: ____________________

Date of Last Visit: ____

Primary Care Psychiatrist: ☐ Y ☐ N Name:____________________________ Phone: ____________________

Date of Last Visit: ____

Are you currently taking any medication or homeopathic? Y ☐ N ☐

Name of Current Medication	Dosage	Frequency	Purpose	Prescribing Doctor

HEALTH HISTORY

Please list past and current medical conditions (major illness/injuries/surgeries/etc.)

What	When	Treatment

Are you in physical pain? Y ☐ N ☐ If yes, where? ____

What type of Pain do you experience? Dull ☐ Sharp ☐ Nagging ☐ Burning ☐ Other: ________________

How long have you experienced this type of Pain? ____

Please rate your Pain today: 1 2 3 4 5 6 7 8 9 10 On a good day:_______ On a bad day: __________

Immunizations up to date? Y ☐ N ☐ If no, please explain: ____

____

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MINOR' S HISTORY

In What City/State was minor born? ______________________________

Where did the minor grow up?______________________________

Who raised the child?______________________________

Number of living siblings/step-siblings: ________ Number of deceased siblings/step-siblings: __________

What position does the child have in birth order? ______________________

☐Family Involved in treatment ☐Family uninvolved in treatment

Please explain: ______________________________

____

____

____

Pregnancy: Planned ☐ Yes ☐ No Length of Pregnancy: ______________________

While Pregnant did mother smoke? ☐ Yes ☐ No Did father smoke? ☐ Yes ☐ No

While Pregnant did mother use alcohol? ☐ Yes ☐ No Did father use alcohol? ☐ Yes ☐ No

While Pregnant did mother use drugs? ☐ Yes ☐ No Did father use drugs? ☐ Yes ☐ No

Please explain usage: ______________________________

____

Any complications during pregnancy? ☐ Yes ☐ No Explain: ______________________

____

BIRTH

Length of Labor:_______ Induced ☐ Caesarian ☐ Natural ☐

Describe any complications with delivery: ______________________________

____

____

Baby's Birth Weight: ________________ Baby's Birth Length: ____________________

Describe any complications for mother and baby after birth: ______________________

____

____

Length of Hospitalization: Mother: __________________ Child: ________________________

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INFANCY/TODDLERHOOD

Describe your child as an infant: ____

____

Describe any changes/differences as a toddler: ______________________________________

____

Describe any past/current problems with wetting or soiling: ____________________________

____

Describe any past/current sleeping problems: ____

____

DEVELOPMENTAL HISTORY

Age at which Child:

Sat Alone: ______________ Took First Step: __________ Spoke First Word: _____________

Spoke Sentence: __________ Weaned: ______________ Fed Self: ___________________

Toilet Trained: ___________ Dry During Day: __________ Dry During Night: _____________

Dressed Self: ____________ Tied Shoelaces: __________ Rode 2-Wheel Bike: ____________

PAST/CURRENT DIFFICULTIES WITH THE FOLLOWING:

- ☐ Attachment to security object
- ☐ Nervous Habits
- ☐ Over Active
- ☐ Imaginary Friends
- ☐ Separation Difficulties
- ☐ Masturbation
- ☐ Thumb Sucking
- ☐ Teeth Grinding
- ☐ Social Contacts
- ☐ Temper Tantrums
- ☐ Emotional Difficulties
- ☐ Sexual Difficulties
- ☐ Thumb Sucking
- ☐ Fascinations
- ☐ Head Banging
- ☐ Short Attention Span
- ☐ Anger Difficulties
- ☐ Other:

Please describe the issue and when it began: ____

____

____

____

____

Age of Following Developments: (if applicable)

Voice Change: _______Breast Development: ________Body Hair: __________Menstruation: _____________

SOCIAL BEHAVIOR

How well does your child get along with other children his/her age: ______________________________________

____

____

Does child have friends: ☐ Yes ☐ No Duration of best friendship: ____________________

Your opinion of child's choice in friends: ____

____

Family members that your child is close to: ____

____

Family members your child has difficulties with: ____

____

DESCRIBE THE FOLLOWING:

Recent changes in child's feelings/attitudes toward family members: ________________________

____

Physical, emotional, sexual abuse Past/Present: ____

____

Problem Behaviors: ____

____

____

Effect of problem behaviors on other family members: ____________________________________

____

Child's response to authority figures and reasonable limit setting: __________________________

____

Geographical moves (how many, when, where, child's response): ___________________________

____

EDUCATION

Present School: ________________________ School Phone #: ___________________________

Grade: ____________ Teacher: ________________ Counselor: ______________________

Placement in gifted/special education program: ____

Retention or acceleration in grade placement: ____

Past/Current behavioral issues in school: ____

____

Past/Current academic performance in school: ____

____

Your opinion of child's academic performance: ____

____

Child's attitude towards school: ____

____

Other information about academics: ____

____

ALCOHOL / SUBSTANCE USAGE

Preferred Substance: ☐ Alcohol ☐ Tobacco ☐ Narcotics ☐ Prescription ☐ Other

Date of last use: ____

Type and amount of usage: ____

Age usage began?____________________ How often is use/consumption?______________________

Has child ever had any legal problems related to his/her use/consumption? ☐ Yes ☐ No

Have child ever had any relationship problems related to his/her use/consumption? ☐ Yes ☐ No

Has child use/consumption ever become a problem? ☐ Yes ☐ No

SUPPORT SYSTEM (Check all that apply)

☐ Adequate social support ☐ Recent move/relocation ☐ Conflict with peers

☐ Financial problems ☐ Transportation problems ☐ Housing problems

☐ Isolative ☐ Relationship problems ☐ Recent Loss

Please list involvement in community resources: ____

____

____

EMPLOYMENT

Has child had any after school employment? ☐ Yes ☐ No

If Yes Where: ______________________________ Dates: ______________________________

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LEGAL

Is child presently on probation? ☐ Yes ☐ No

If yes, reason:__________________________ How Long: ______________________

Is child currently involved in active legal situation? ☐ Yes ☐ No

If yes, please describe and indicate court/hearing/trial dates: ________________________________

____

INTERESTS/HOBBIES

Do you participate in any cultural activities related to your social or ethnical background? ☐Yes ☐No

Please list your hobbies or interests: ____

____

SPIRITUALITY

Do you practice a faith or religion? ☐Yes ☐No If so, please identify: ______________________

Would you like faith to be a part of treatment? ☐Yes ☐No

If Yes, please describe what this might look like? ____

____

TREAMENT EXPERIENCES

	YES	NO	INPATIENT/ OUTPATIENT	WHEN	WAS IT HELPFUL?		
Individual Counseling					YES	SOME	NO
Family Counseling					YES	SOME	NO
Developmental Therapy/PSR					YES	SOME	NO
Psychiatric Services					YES	SOME	NO
Drug/Alcohol/Sexual Addiction Treatment					YES	SOME	NO
Self-Help Group					YES	SOME	NO
Hospitalization					YES	SOME	NO

Have you or are you currently contemplating harming yourself? ☐ YES ☐ NO ☐ Past ☐ Present
Have you or are you currently contemplating ending your life? ☐ YES ☐ NO ☐ Past ☐ Present
Has anyone in your immediate family attempted or completed suicide? ☐ YES ☐ NO ☐ Past ☐ Present

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CURRENT CONCERNS

A. What brought you into treatment: ____

____

B. What are your expectations for treatment: ______________________________________

____

C. What is the one thing that you want me to know about you today: ____________________

____

PRESENTING PROBLEMS/FEELINGS/EXPERIENCES (Check all that apply)

- ☐ Aggressive Behavior
- ☐ Alcohol Abuse/Dependency
- ☐ Anger
- ☐ Anxiety
- ☐ Change in Appetite
- ☐ Compulsions
- ☐ Cutting/Injuring
- ☐ Delusions/Hallucinations
- ☐ Depression
- ☐ Easily Annoyed
- ☐ Easily Distracted
- ☐ Eating Disorder
- ☐ Emotional Abuse
- ☐ Excessive Worry
- ☐ Family Issues
- ☐ Fatigue
- ☐ Fearful
- ☐ Financial
- ☐ Friendship
- ☐ Grief/Loss
- ☐ Guilt/Worthlessness
- ☐ Headaches
- ☐ Hearing Things
- ☐ Hopeless
- ☐ Impulsivity
- ☐ Insomnia
- ☐ Intimacy
- ☐ Irritable
- ☐ Life Decision
- ☐ Loss of Pleasure
- ☐ Mania
- ☐ Medical/Organic Condition
- ☐ Mood Instability
- ☐ Muscle Tension
- ☐ Pain
- ☐ Panic
- ☐ Paranoia
- ☐ Parenting
- ☐ Physical Abuse
- ☐ Poor Concentration
- ☐ Racing Thoughts
- ☐ Relationships
- ☐ Restless
- ☐ Sadness
- ☐ School
- ☐ Seeing Things
- ☐ Self-Destructive Behavior
- ☐ Sex Compulsion/Dependency
- ☐ Sexual Abuse
- ☐ Sexuality
- ☐ Sleeping Too Little
- ☐ Sleeping too much
- ☐ Spirituality
- ☐ Stomachaches
- ☐ Stress
- ☐ Substance Abuse/Dependency
- ☐ Suicidal Ideation
- ☐ Tearful
- ☐ Trauma
- ☐ Uncertain
- ☐ Work
- ☐ Other: ____________________

____

Please identify and rate the six feelings or experiences that are most troubling for you currently from most severe to least severe:

#1: ______________________ #2: ______________________ #3: ______________________

#4: ______________________ #5: ______________________ #6: ______________________

Approximately how long have these been bothering you? ________________________________

Approximately how much distress do you believe these problems are causing in your life?

Mild (less than once a week) Moderate (1-2 times per week) Severe (4-5 times per week) Impairing (Daily)

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AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I request that ____ provide professional service to,
(Counselor Name)

☐ myself ______________________________ ☐ and/or ___________________________________,

who is my ____.

- I agree to pay the counselors stated fees as listed in Informed Consent document and posted in the Treasure Wellness Lobby.
- I agree that this financial relationship with this counselor will continue as long as the counselor provides services or until I inform him/her, in person or by certified mail that I wish to end this professional relationship.
- I agree to meet with my counselor at least once before stopping therapy.
- I agree to pay for service provided to me or stated client up until the time that I have fulfilled my financial responsibility.
- I agree that I am responsible for the charges of service provided by this counselor, although other persons or insurance companies may make payment on my or clients behalf.

_______________________________ _______________ _______________
Client/Guardian Signature Relationship Date

_______________________________ _______________ _______________
Client/Guardian Signature Relationship Date

I, the counselor, have discussed the issues above with the client and/or the person representing 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.

_______________________ _______________________ _______________
Counselor Counselor Signature Date

PAYMENT INFORMATION

Acceptable forms of payment: Cash, Check, Credit, and Debit
Please make checks payable to: Above listed counselor or as directed

For ongoing credit and debit payments:

Name as it appears on Card:____________________________ Amount of Payment: _______________

Billing Zip Code: _____________ Frequency of Payment: ____________________

Card#:__________________________ Expiration Date:_____________ Security Code: _______

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INSURANCE RESPONSIBILITY and ASSIGNMENT OF BENEFITS

FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am financially responsible to my providing counselor for any charges not covered by my health care benefits. It is my responsibility to notify my counselor of any change in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives a claim. I understand that I am responsible for the entire balance of the bill.

INSURANCE INFORMATION (Client responsible for all charges not covered by insurance)

Client Name:_______________________________ Date of Birth: ____________________

Primary Insurance: ☐ Y ☐ N CoPay: ____________ Out of Pocket Payment: ☐ Y ☐ N

Primary Insurance Co: ____________________ Policy #:________________ Group #: ____________

Primary Insurance Co. Phone #:____________________________

Policy Holder's Name:________________________________ Relationship to Client: ____________

Policy Holder's Date of Birth:____________________ Policy Holder's Phone#: ______________________

Policy Holder's Address: ____

Secondary Insurance: ☐ Y ☐ N CoPay: ___________

Secondary Insurance Co:____________________ Policy #:________________ Group #: ____________

Secondary Insurance Co. Phone #:__________________________

Policy Holder's Name:________________________________ Relationship to Client: ____________

Policy Holder's Date of Birth:____________________ Policy Holder's Phone#: ______________________

Policy Holder's Address: ____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) if choosing to use my insurance benefits, assign directly to my providing counselor listed below all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand it is my responsibility to pay any deductible amount, co-insurance, or any other balances not paid by my insurance company or pay the full client fee if I have no insurance coverage. I authorize the release of necessary information to file said claim with my insurance or third party payer.

________________________	________________________	____________
Client	Signature	Date
________________________	________________________	____________
Parent/Guardian	Parent/Guardian Signature	Date
________________________	________________________	____________
Counselor	Counselor Signature	Date

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CONSENT FOR TREATMENT AND ACKNOWLEDGMENT

I, hereby acknowledge that I have received, read and been given an opportunity to ask questions regarding the following Treasure Wellness Counseling Center business documents. I understand that if I have any questions or concerns regarding these business documents, I may contact my clinician or the Treasure Wellness office.

- ☐ Your Counselor's Informed Consent and Procedures
- ☐ Treasure Wellness Informed Consent and Procedures
- ☐ Client Bill of Rights
- ☐ Agreement to Pay
- ☐ Cancellation/No Show Policy – May Be Subject to ½ Billable Rate
- ☐ Insurance Assignment of Benefits
- ☐ Emergency Procedures
- ☐ HIPAA-Notice of Privacy
- ☐ Authorization for Live Observation
- ☐ Authorization for Masters Level Intern Audio-Video Recording

I, voluntarily consent to the live observation of session by Treasure Wellness Counseling Center, Interns, Supervisors or Intern University Representative.

☐ YES ☐ NO

I, voluntarily consent to Audio-Video recording of sessions by Treasure Wellness Counseling Center Interns for the educational training of Interns.

☐ YES ☐ NO

I, voluntarily consent to participate in the intake, assessment and treatment process. I also acknowledge the following:

1. I have been given the opportunity for discussion of any concerns that I have regarding treatment.
2. I will be informed and take part in my treatment and goal planning.
3. I have been given no guarantee of treatment outcomes.
4. I have been informed of any and all fees associated with my treatment.
5. Treasure Wellness Counseling Center will use and disclose personal health information for treatment and to receive payment for services provided.

Printed Name of Client	Signature of Client	Date
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
Printed Name of Counselor	Signature of Counselor	Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date initiated: ____________

Client's Name: ____________________ ____________________ ____________________
First Name Middle Name Last Name

Client's Date of Birth: ____________________

I, ________________________________ authorize the release of my confidential protected health information, as described in my directions below. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

______ **Release To:** ______ **Obtain From:** ______ **Exchange With:**

____
Name of Clinician, Office, Individual

________________________________ ____________________ ____________________
Address Phone Fax

Information to be released:

- ☐ **Authorization for Psychotherapy Notes**
- ☐ **Authorization for History/Intake**
- ☐ **Authorization for Diagnosis**
- ☐ **Authorization for Dates of Treatment/Attendance**
- ☐ **Other (describe information in detail)**: ____

____
____

The reason I am authorizing release is:

- ☐ **Evaluation/Assessment and/or Coordinating Treatment Efforts**
- ☐ **Other (describe):**

This Authorization will expire 180 Days after initiated

I understand, that I have the right to refuse the release of any protected health information. I may revoke my consent to release at any time except to the extent that the information has already been released.

Signature of Client: ________________________________ **Date:** ____________________

Signature of Parent/Guardian: ________________________________ **Date:** ____________________

Signature of Counselor: ________________________________ **Date:** ____________________