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:** _____

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**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: _____

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**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: _____

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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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# 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 |