INFORMATION FOR MINORS

Name of Minor: _____

Address: _____

Telephone: _____

Social Security No.: _____

Date of Birth: _____ Grade in School: _____

Name of School: _____

PARENT INFORMATION:

Name of Parent/Guardian: _____

Social Security or Driver's License No.: _____

Address (If different from Minor): _____
_____

Employer: _____

Telephone: (home) _____ (work) _____
Cell phone: _____ (emergency) _____

Name of other parent: _____

Social Security or Driver's License No.: _____

Address (If different from Minor): _____
_____

Employer: _____

Telephone: (home) _____ (work): _____

Cell phone: _____

Minor Intake 2

FAMILY and DEVELOPMENTAL INFORMATION

BIOLOGICAL PARENTS

___Together, in same home ___Separated ___Divorced ___Other

_____

Minor lives with:

Person	Relationship	Age

VISITATION WITH OTHER PARENT: (Describe)_____

_____

_____

Do Both Parents Agree with this Evaluation/Treatment? _____Yes _____No

Does either parent (or stepparent) suffer from mental illness?_____Yes _____No
Does either parent (or stepparent) suffer from substance abuse? ____Yes ____No
Explain "yes" answer(s)_____

_____

Was pregnancy and birth of Minor without complication? (Explain complications):

_____

_____

Developmental Issues? _____

_____

Minor Intake 3

Were developmental "milestones" accomplished within normal limits?
(Ie, crawling, sitting, walking, talking, etc)_____

List all health issues, particularly chronic problems (ie, asthma, allergies, diabetes, etc):

Medications: _____

School:

Academic Issues: _____

Behavior Issues: _____

RISK FACTORS:

Has minor ever:

____attempted suicide
____run away from home
____binged and/or purged food
____expressed thoughts of harming self or others
____been in fights
____been arrested
____started fires
____been cruel to animals
____stolen money/property
____been sexually active
____suffered physical/sexual abuse
____cut self/tattooed self
____expressed thoughts of death
____destroyed property
____had phobias
____bedwetting after age 7
____tattoos or piercing other than ear piercing
____used drugs
____expressed delusional thinking

What would you like from evaluation/treatment? _____

Minor Intake 4

I agree to be financially responsible for any evaluation, treatment, consultation, or other service provided by Dr. Michael Eastridge or his associates. I understand that I have the right to refuse any recommended service. I agree to the release of information necessary to process insurance forms/requests, in order to obtain payment from my insurance company.

I agree to reasonable confidentiality between the Minor and Dr. Eastridge. I understand that there are limitations to confidentiality and that Dr. Eastridge may recommend different levels of confidentiality for minors of different ages or abilities. I understand that I may request, at the beginning of any session with the Minor, to participate in the session, either separately or with the minor.

I understand that sessions are scheduled to last for 45 minutes, but that sometimes sessions with minors may end a little earlier or later, depending upon the issue being discussed and the minor's ability to participate in a session of that length on a given day. Sometimes an issue may be addressed in a shorter period of time, and for therapeutic reasons, other issues may not be addressed on that day, and the session ended.

I understand that there is no service in this office to babysit children during sessions, and that I am responsible for the safety and entertainment of any children in my care, while at this office. I understand that I may leave the office during a session, but that I must leave a telephone number so that I may be reached, if needed, and that whenever a child is of an age or developmental ability such that he/she may not be left in the waiting room unattended, I will remain in the office during the appointment.

I understand that, unless I specifically retain Dr. Eastridge as an expert for trial, that he is employed as a treating/evaluating psychologist. Dr. Eastridge will not prepare reports for court, custody hearings, etc. as a regular part of treating/evaluating patients unless specifically retained as an expert. I understand that my insurance will not cover this service, and that I will be financially responsible for any such service or expenses associated with legal proceedings.

I understand that I am responsible for acquiring consent for treatment from the other parent, when applicable. I am responsible for informing Dr. Eastridge, at the beginning of treatment, when the other parent may object to evaluation/treatment.

Parent/Guardian signature: _____

Date: _____

I have the legal right to seek psychological services and to give consent for evaluation treatment of this minor.

_____
Minor

_____ Date: _____
Parent/Guardian signature: