Map

Description automatically generated with medium confidence Amy Gaines, LCSW, LLC

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\_\_\_\_\_ Active New Admission\_\_\_\_\_Re-Admission Date:\_\_\_/\_\_\_/\_\_\_ Case#\_\_\_\_\_\_\_\_\_\_\_\_

CHILD INFORMATION: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_/\_\_\_/\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alternate Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_ Gender: \_\_\_ Male \_\_\_\_Female Ethnicity: \_\_\_\_\_\_\_\_\_\_

**MENTAL HEALTH QUESTIONNAIRE**

Answer all the questions, indicating (1) Never, (2) Sometimes, or (3) Often

\_\_\_\_ Talks back to authority figures (attitude)

\_\_\_\_ Has problems with making or keeping friends

\_\_\_\_ Excitable, impulsive

\_\_\_\_ Wants to run things

\_\_\_\_ Sucks or chews on thumb, clothing, blankets, etc.

\_\_\_\_ Cries easily or often

\_\_\_\_ Emotionally reactive

\_\_\_\_ Tendency to daydream

\_\_\_\_ Difficulty with learning

\_\_\_\_ Fidgety (always squirming, restless, and moving around)

\_\_\_\_ Experiences fear and anxiety in new situations/meeting new people

\_\_\_\_ Destructive (breaks things)

\_\_\_\_ Difficulty accepting responsibility for actions (blames others for mistakes)

\_\_\_\_ Lies

\_\_\_\_ Does not follow directions

\_\_\_\_ Shy (does not assert self)

\_\_\_\_ Has problems with speech (stuttering or whining)

\_\_\_\_ Steals

\_\_\_\_ Argumentative

\_\_\_\_ Disrespectful

\_\_\_\_ Pouts

\_\_\_\_ When hurt or angered by someone, holds a grudge

\_\_\_\_ Develops headache or stomachache when stressed

\_\_\_\_ Worries unnecessarily

\_\_\_\_ Does not complete tasks

\_\_\_\_ Emotionally sensitive and easily hurt

\_\_\_\_ Difficulty expressing feelings

\_\_\_\_Temper tantrums

\_\_\_\_ Frequent disruptions at school Score: \_\_\_\_\_\_\_\_\_\_\_\_

**PARENT(S)/GUARDIAN(S) INFORMATION:**

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **HOUSEHOLD COMPOSITION (Please list everyone in the household and their relationship to the child)** | | | |
| NAME | RELATIONSHIP | NAME | RELATIONSHIP |
| 1. |  | 6. |  |
| 2. |  | 7. |  |
| 3. |  | 8. |  |
| 4. |  | 9. |  |
| 5. |  | 10. |  |

Are both biological parents living in the household? \_\_\_\_ If not, when did the separation occur? \_\_\_\_\_\_\_\_\_\_\_

Has anything occurred within the home that would affect the child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a history of substance abuse within the family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Educational/Vocational History**

Highest Grade Level Completed: \_\_\_\_\_\_\_\_ School Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attitude Towards School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problems at School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does your child have an IEP? YES­­­\_\_\_ NO\_\_\_\_**  **IF SO, UNDER WHAT ELIGIBILITY CATEGORY IS THE CHILD CLASSIFIED ON THE IEP? CIRCLE ONE** | | | | |
| Autism | Emotional Disturbance | Multiple Disabilities | Speech/Language Impaired | Other Health Impaired |
| Deaf-Blindness | Hearing Impairment | Orthopedic Impairment | Traumatic Brain Injury | OHI-ADD/ADHD |
| Developmental Delay  (3-5) | Intellectual Disability | Specific Learning Disability | Visual Impairment | To Be Determined |
| Do you believe this captures your child’s disability? YES NO | | If no, please discuss what you believe his/her issues are: | | |
|  | | | | |
|  | | | | |
|  | | | | |

**MEDICAL HISTORY**

Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complications at Birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has child been hospitalized? \_\_\_\_ Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug or Food Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History of Medical Conditions**:

|  |  |  |  |
| --- | --- | --- | --- |
| * Asthma | * Communicable Disease | * Kidney Disease | * Heart Disease |
| * Diabetes | * Major Injuries | * Sickle Cell/Trait | * Seizures |
| * High Blood Pressure | * Respiratory Disease | * Genetic Injuries | |
| * Birth Defects | * Other | * Surgery | |

**MENTAL HEALTH HISTORY:**

Has the child had previous inpatient/outpatient psychiatric treatment, family history of mental illness, or homicidal/suicidal behavior, other counseling and/or other therapeutic experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is the child currently seeing a mental health professional for counseling/psychiatric services? \_\_\_\_\_\_\_\_\_\_

Mental Health Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO BILL**

Insurance: \_\_\_\_ Medicaid \_\_\_\_CHIPS \_\_\_\_Blue Cross/Blue Shield \_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration/Renewal Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of any medical or other information necessary to process this claim.

*Patient or authorized person’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_*

**CONFIDENTIALITY POLICY/DUTY TO WARN**

All information shared with the therapist shall be treated as confidential unless the client threatens to harm him/herself or others, or if (s)he reports child abuse to the therapist. No records shall be shared with anyone without the written consent of the child’s parent or legal guardian, except as stated in the previous authorization. The only exception to this policy would be if the records were subpoenaed by a court order.

*Patient or authorized person’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_*

What concerns you most about your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CONSENT TO TREATMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give consent for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To receive an initial assessment and, if recommended, individual, family and/or group therapy by Amy Gaines, LCSW, or another affiliated licensed therapist of hers.

*Patient or authorized person’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_*

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

The undersigned authorizes Amy Gaines, LCSW, or her affiliated therapist to provide appropriate therapy, including individual, group, and/or family therapy or referrals. I consent to the use of sharing my health records for treatment and payment and operation purposes as described to me in the Notice of Privacy Practices (client has been given a copy of these practices). Please initial: \_\_\_\_\_

*Patient or authorized person’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_*

**TELEPHONE & EMERGENCY PROCEDURES:**

If you need to contact Amy Gaines, LCSW between sessions, please leave a message at the answering service 601-937-2041 and your call will be returned as soon as possible.

Amy Gaines, LCSW checks her messages a few times during the daytime only, unless she is out of town.

If an emergency arises, call 911 for immediate help and then call Amy Gaines and indicate your situation clearly in your message and if you need to talk to someone right away call the 24-hour crisis line in your county:

Lincoln/Madison Counties: 601-823-2300

Marion, Covington, Jeff Davis Counties: 800-681-0798

Claiborne, Franklin, Lawrence, Pike Counties: 877-353-8689

Please do not use email or faxes for emergencies because Amy Gaines, LCSW, may not always check her email or faxes in a timely manner to deal with your emergency.