

M.E.N.D. CENTER

15-Minute Consultation Form

CHILD INFORMATION

Child's Full Name:		Date of Birth:
Age:	Address:	
Minors telephone # (if applicable):		Primary language spoken by child:

PARENT / GUARDIAN INFORMATION

	Legal Name/Relationship	Address (if different)	Phone / Email/
Parent/Guardian 1			
Parent/Guardian 2			
Preferred contact method	☐ Phone ☐ Email ☐ Text ☐ Other: _____		
Best time to contact			

LEGAL RIGHTS / CONSENT

Who currently has legal authority to consent to the child's mental health treatment? (Check all that apply)

- ☐ Biological Mother
- ☐ Biological Father
- ☐ Adoptive Mother
- ☐ Adoptive Father
- ☐ Court-Appointed Legal Guardian
- ☐ Sole Managing Conservator
- ☐ Joint Managing Conservator
- ☐ Foster Parent (if authorized)
- ☐ Department of Family and Protective Services (DFPS/CPS) Representative
- ☐ Other (please specify): _____
- ☐ Unsure

Have any parental rights been terminated or limited by a court?

- ☐ No
- ☐ Yes (briefly explain): _____

Are there any legal, custody, or court-related circumstances that are relevant to your child's treatment or that influenced your decision to seek services? (Examples include custody or conservatorship arrangements, guardianship, divorce or separation, court orders, CPS involvement, foster care, adoption, juvenile probation, or other legal matters.)

- ☐ No
- ☐ Yes (briefly describe): _____

Are there any current or anticipated legal proceedings involving the child or family that may affect treatment? (Examples include custody litigation, CPS investigations, criminal cases, or court hearings.)

- ☐ No
- ☐ Yes (briefly describe): _____

Note: If applicable, legal documentation (e.g., custody orders, conservatorship orders, guardianship papers, or court orders) may be requested before services begin.

PAYMENT / INSURANCE

How will fees be paid?	☐ Self-pay ☐ Insurance ☐ Other
Insurance Company <i>(Required if applicable)</i>	
Member/Subscriber Name	
Member ID / Group Number / Subscriber Date of Birth	

PRESENTING CONCERNS

What led you to seek therapy for your child at this time?	
How long have these concerns been present?	
Where are the concerns occurring? <i>(Check all that apply)</i> ☐ Home ☐ School/daycare ☐ With peers ☐ Bedtime/sleep ☐ Transitions ☐ Other: _____	Main concerns reported <i>(Check all that apply)</i> ☐ Anxiety/fears ☐ Sadness/withdrawal ☐ Anger/aggression ☐ Behavioral concerns ☐ School concerns ☐ Social concerns ☐ Family changes ☐ Grief/loss ☐ Trauma/stressful experience ☐ ADHD/self-regulation ☐ Other: _____

SAFETY SCREENING

Suicidal Ideation ☐ No ☐ Yes (briefly explain): ☐ Historical
Homicidal Ideation ☐ No ☐ Yes (briefly explain) ☐ Historical
Are there any safety concerns? <i>Examples: self-harm statements, self-injurious behavior, aggression toward others, running away, drug/alcohol use, unsafe behavior, abuse/neglect concerns, or immediate crisis.</i> ☐ No ☐ Yes ☐ Historical (briefly explain):
Has the child received prior services? ☐ No ☐ Yes - check all that apply: ☐ Therapy/counseling ☐ School counseling ☐ Psychological testing ☐ Autism/developmental services ☐ Speech therapy ☐ Occupational therapy ☐ Psychiatric care/medication management ☐ Skills-based/community mental health services ☐ Other: _____

Has your child ever been diagnosed by a healthcare or mental health professional with any of the following?

(Check all that apply.)

- ☐ ADHD
- ☐ Autism Spectrum Disorder
- ☐ Anxiety Disorder
- ☐ Depressive Disorder
- ☐ PTSD (Posttraumatic Stress Disorder)
- ☐ Oppositional Defiant Disorder (ODD)
- ☐ Disruptive Mood Dysregulation Disorder (DMDD)
- ☐ Bipolar Disorder
- ☐ Obsessive-Compulsive Disorder (OCD)
- ☐ Other: _____
- ☐ None

Are there any medical, physical, sensory, or accessibility needs we should be aware of to help us prepare for your child's visit? (Check any that apply)

- ☐ Uses a wheelchair or mobility device
- ☐ Hearing impairment
- ☐ Vision impairment
- ☐ Chronic medical condition
- ☐ Seizure disorder
- ☐ Other: _____
- ☐ None

Is your child currently receiving:

- ☐ Individual therapy
- ☐ Family therapy
- ☐ Skills training
- ☐ ABA
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Psychiatry
- ☐ Psychological testing
- ☐ Other: _____
- ☐ None

SCHEDULING AVAILABILITY

Preferred appointment days/times	
Preferred service format?	☐ In-person ☐ Telehealth (if appropriate) ☐ Hybrid
Preferred language	☐ English ☐ Spanish ☐ Both

ADDITIONAL INFORMATION

Is there anything else you would like us to know about your child or your family's concerns at this time?

REFERRAL SOURCE

How did you hear about M.E.N.D. Center?

- ☐ Pediatrician
- ☐ School
- ☐ Friend/Family
- ☐ Psychology Today
- ☐ Google
- ☐ Facebook
- ☐ Instagram
- ☐ Insurance Directory
- ☐ Church
- ☐ Other: _____