REGAIN BALANCE
Counselling, Health & Wellbeing
PO Box 24 Meadows SA 5201
E admin@regainbalance.com.au
W: www.regainbalance.com.au

CHILD INFORMATION & PARENTAL AGREEMENT (ONE PER CHILD)

Name of child: _____ Date of Birth: _____ Age: ____

Name of parents/guardians: _____

_____

Address: _____

Contact Phone Numbers: _____ or _____

What is the main concern, reason, or issue for you bringing your child to counselling today?

Please indicate if any of the following are relevant to your child:

☐ Anger	☐ Difficulty relaxing	☐ Self-esteem
☐ Anxiety/Worry	☐ Eating difficulties/disorders	☐ Excessive negative talk.
☐ Bullying	☐ Family separation	☐ Self-harm
☐ Birth difficulties	☐ Excessive or irrational fears	☐ Sleeping difficulties.
☐ Changes in behaviour	☐ Grief/loss	☐ Violent behaviour
☐ Control of emotions	☐ Friendships/social interactions	☐ Withdrawal
☐ Cruelty to animals	☐ Lack of empathy	☐ Trauma
☐ Difficulty self-calming	☐ Learning difficulties	☐ Obsessive behaviours
☐ Depression	☐ Night terrors	☐ Development concerns

Any other comments you would like to share:

_____

CHILD'S MEDICAL HISTORY

1. Pregnancy
   - ☐ Full-term
   - ☐ Premature
   - ☐ Complications

2. Child's birth
   - ☐ Natural
   - ☐ Caesarean
   - ☐ Complication (including post-natal depression)

REGAIN BALANCE
Counselling, Health & Wellbeing
PO Box 24 Meadows SA 5201
E admin@regainbalance.com.au
W: www.regainbalance.com.au

3. Has your child been diagnosed with?

☐ Allergies

☐ Asthma

☐ Diabetes

Is your child currently taking any regular prescribed medication?

_____

4. Has your child ever been assessed for?

☐ Autism Spectrum disorders (ASD's)

☐ Asperger Syndrome

☐ Attention deficit disorder (ADD) or Attention Hyperactivity Disorder (ADHD)

☐ Epilepsy

☐ Headaches

☐ Mental Illness

☐ Physical injuries/Illness

☐ Problems with back, neck, shoulders

☐ 'Sore tummy' (cramps, ache)

☐ Other – please specify _____

5. Please indicate if any of the changes listed below have been experienced by child/family in the past two years:

☐ Birth of a sibling

☐ Changed school or started school

☐ Child living with other carer's

☐ Financial hardship or job loss in family

☐ Death of close friend or relative

☐ Parent remarries or new partner

☐ Family separation or divorce

☐ Serious illness/injury in family

☐ Moved to a new house

☐ Other significant change (please specify) _____

_____

REGAIN BALANCE
Counselling, Health & Wellbeing
PO Box 24 Meadows SA 5201
E admin@regainbalance.com.au
W: www.regainbalance.com.au

PARENT OR GUARDIAN CONSENT FORM FOR CLIENTS UNDER 18 YEARS

Name(s) of Parent(s) and/or Guardian(s):

1. _____

2. _____

3. _____

4. _____

CONFIDENTIALITY & INFORMED CONSENT FOR MINORS

When working with minors, confidentiality and informed consent must be clearly understood by both the child and the parent/guardian. It is important that children and teenagers feel comfortable sharing their concerns, fears, and anxieties in a safe environment. To achieve this, they need to feel confident that their privacy is respected and that they have some control over what information is shared.

However, children often need parental involvement to make positive changes. Parents play an essential role in supporting their child's well-being. To help the child and family, I will provide regular updates to parents while maintaining the privacy of the child where appropriate. These updates will focus on general themes and concerns rather than specific details, and I will seek the child's consent before sharing any sensitive information.

In some cases, family therapy sessions may be recommended, where both the child and parents can work together. Please note that all the same limits to confidentiality that apply to adults also apply to children and adolescents.

In South Australia, individuals aged 16 and over have the right to consent to their own medical treatment, including counselling, under the **Consent to Medical Treatment and Palliative Care Act 1995 (SA)**. For individuals aged 14 and 15, they may consent to medical treatment if they are deemed capable of understanding the nature and consequences of the treatment (the "mature minor" principle).

REGAIN BALANCE
Counselling, Health & Wellbeing
PO Box 24 Meadows SA 5201
E admin@regainbalance.com.au
W: www.regainbalance.com.au

This means that young people aged 16 and over have the right to make decisions regarding their counselling and whether they wish to involve their parents or guardians. For those aged 14 and 15, the healthcare provider will assess their maturity to determine if they can consent independently.

Although I encourage young people to involve their parents, the final decision rests with the young person unless there is a risk to their safety or well-being.

By signing below, I/we confirm that I have read and understood the information about confidentiality and informed consent for my child.

I/We understand that if my child is 16 or older, they may choose not to inform me about their counselling sessions. I have had the opportunity to ask any questions, and they have been answered.

I/We also understand that participation in counselling is voluntary, and my child has the right to refuse or discontinue counselling at any time.

I/We consent to my child receiving counselling with Suzanne Grabowski at Regain Balance Counselling, Health & Wellbeing.

Parent or Guardian Name: _____

Signature: _____

Date: _____

Parent or Guardian Name: _____

Signature: _____

Date: _____