



CONFIDENTIAL CHILD REGISTRATION & INFORMATION FORM (ONE PER CHILD)

Name of child:

Date of Birth

Age:

Name of parents/guardians:

Address:

Contact Phone:

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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Difficulty relaxing | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Anxiety/Worry | <input type="checkbox"/> Eating difficulties/disorders | <input type="checkbox"/> Excessive negative talk. |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Family separation | <input type="checkbox"/> Self-harm |
| <input type="checkbox"/> Birth difficulties | <input type="checkbox"/> Excessive or irrational fears | <input type="checkbox"/> Sleeping difficulties. |
| <input type="checkbox"/> Changes in behaviour | <input type="checkbox"/> Grief/loss | <input type="checkbox"/> Violent behaviour |
| <input type="checkbox"/> Control of emotions | <input type="checkbox"/> Friendships/social interactions | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Lack of empathy | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Difficulty self-calming | <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Obsessive behaviours |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Night terrors | <input type="checkbox"/> 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
- Complications (including post-natal depression)



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:

- | | |
|--|--|
| <input type="checkbox"/> Birth of a sibling | <input type="checkbox"/> Changed school or started school |
| <input type="checkbox"/> Child living with other carer's | <input type="checkbox"/> Financial hardship or job loss in family |
| <input type="checkbox"/> Death of close friend or relative | <input type="checkbox"/> Parent remarries or new partner |
| <input type="checkbox"/> Family separation or divorce | <input type="checkbox"/> Serious illness/injury in family |
| <input type="checkbox"/> Moved to a new house | <input type="checkbox"/> Other significant change (please specify) |



PARENT OR GUARDIAN CONSENT FORM FOR CLIENTS UNDER 18 YEARS

Name(s) of Parent(s)/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).



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/Guardian Name:

Signature:

Date:

Parent/Guardian Name:

Signature:

Date: