PRE-ASSESSMENT

(PLEASE NOTE: Information provided on this form is protected as confidential information.)

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- ❑ NO
- ❑ YES (if so, please provide therapist/practitioner) : _____

Is your child currently taking medication any prescription medication and/or ever been prescribed medication?

- ❑ NO
- ❑ YES (if so, please list) : _____

How would you rate your child's current physical health? (Please circle one.)

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your child's current sleeping habits? (Please circle one.)

Poor Unsatisfactory Satisfactory Good Very Good

Is your child currently experiencing overwhelming sadness, grief or depression?

- ❑ NO
- ❑ YES (if so, for approximately how long?) : _____

Is your child experiencing anxiety, panic attacks, or have any phobias?

- ❑ NO
- ❑ YES (if so, when did he/she begin experiencing this?) :

  _____

Does your child have any substance problems?

- ❑ NO
- ❑ YES

Does your child have problems in school or at home?

- ❑ NO
- ❑ YES (if so, please describe) : _____

What significant life changes or stressful events has your child experienced lately?

_____

What would you like your child to accomplish out of his/her time in therapy?

_____

Please share any other information about your child that you think is important for counseling:

_____

_____

_____

Insurance Authorization - I authorize the release of any medical or other information necessary to process insurance claims for services rendered. I also request payment of medical benefits to the undersigned physician or party who accepts assignments.

_____

Initials

Consent for Treatment - I have been informed about the information contained in the document pertaining to treatment and agree to abide by its terms during our professional relationship. I understand that I am responsible for payment of any fees which insurance does not pay or cover.

_____
Initials

South Carolina Privacy Notice Form - I have been informed about the information contained in the SC Privacy document and understand how the Health Insurance and Portability and Accountability Act (HIPAA) impacts clinical and medical information about me and how I can get access to this information. I am also aware that should I have any questions concerning this policy I am free to discuss them at our next session or at any time in the future.

_____ _____ _____
Signature Print Name Date

_____ _____
Therapist Signature Date