CROSSROADS CHRISTIAN COUNSELING CENTER

PHONE:812.518.1490
FAX:812.490.8181
CCCGO.COM/COUNSELINGCENTER

SIGNATURES – MINOR

In case of joint (split) custody between parents or guardians we require signed consent by all parties before your child is seen by a therapist. Documentation (e.g., custodial agreement) may be required.

Client Full Name _____ Date of Birth_____

Responsible Party(s) Full Name_____ Relation to Client_____

MISSED APPOINTMENTS

I am financially responsible for my attendance at all scheduled appointments, unless cancelled at least 24 hours in advance. **I agree if I do not cancel to pay $30 for each missed appointment**. Excessive misses may result in termination of counseling or payment of the full fee for missed sessions.

ACCOUNT RESPONSIBILITY

I agree to make payment for all services rendered at the time of my appointment. I understand that if I suspend or terminate my treatment that all outstanding balances are due and payable. I understand that I will be charged based upon the amount of time I am with my counselor. I agree to the fees listed in the Policy statement. I agree that any additional time (consultations, reports, letters, email, etc.) will be prorated and charged to me at the normal rate. CCC also reserves the right to forward your information to a collection service if there is a default on any payment obligations described in this agreement.

COURT AND LEGAL ACTION

Because of the adverse impact on the counseling relationship, I agree that should there be any legal proceedings (such as, but not limited to, divorce, custody, injuries, lawsuits, etc.) that **neither I nor my attorney (or anyone acting on my behalf) will call on my therapist to testify in court or any other proceeding**. Additionally, I agree that **I will not direct the subpoena or request of psychotherapy records** for any potentially adversarial reason.

PRIVACY PRACTICES

I am attesting that **I have received, understand and agree to the Counseling Policies** of CCC including the notice of Privacy Practices. I understand that CCC cannot guarantee that correspondence via fax, email, text or cellular service is completely confidential. If I use or agree to these means of communication, I accept the limitations.

CONSENT FOR TREATMENT

I do hereby seek and consent that my child take part in my treatment with a counselor of Crossroads Counseling Center.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this counselor.

I am aware that I may stop my treatment with this counselor at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment (for example, therapy that has been court-ordered).

MY SIGNATURE INDICATES THAT I HAVE BEEN PROVIDED A COPY OF, AND THAT I UNDERSTAND AND AGREE TO ALL THE TERMS AND CONDITIONS OF THE COUNSELING POLICIES.

Signature of Responsible Party_____ Date_____

Signature of Responsible Party_____ Date_____

Signature of Counselor_____ Date_____

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FAMILY INFORMATION

Name of Parents_____ Phone_____

_____ Phone_____

Emergency Contact if different from above Phone_____

Names of Siblings	Age	Gender	Living where/custody
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Significant others potentially relevant to counseling (e.g., grandparents, step-relatives, etc.)

Name	Relationship
_____	_____
_____	_____
_____	_____

FAMILY STATUS

Are the parents divorced, separated, widowed, or single? f yes, who has legal custody?

Is your child adopted? ☐ Yes ☐ No Are there any issues relevant to treatment?

Where does the child live at this time? If there is joint custody, please describe the schedule:

Are there any concerns about how your child is disciplined?

Is there any significant information about relationships in the family relevant to treatment?

Please describe the parent(s) vocation and typical work schedule:

PRIMARY REASON(S) FOR SEEKING SERVICES (CHECK)

Anger management	Excessive Worry	Coping/Life transitions	Depression
Eating Issues	Anxiety/Fear	Relationships	Health Problems
Sexual/Gender Concerns	Assessment	Trauma	School Problems
Grief/Loss	Birth/Development Issue	Self-Esteem	Learning Disabilities
Other:			

DESCRIPTION OF PRESENT DIFFICULTIES:

Please briefly describe the problem(s) that you want to talk about in counseling (use back if you need additional space):

Please note any significant events (not mentioned previously) related to the development or continuation of your child's problems:

Has your child been in treatment before? ☐ Yes ☐ No Name of counselor and treatment dates:

Would it be helpful for us to contact her or him? ☐ Yes ☐ No

What was helpful and/or were there any problems with the treatment or therapist?

What are your child's feelings about coming here for counseling?

Has your child ever been diagnosed with a psychological disorder? Please describe:

Has your child ever been hospitalized for a psychological/psychiatric reason? If so, please describe and list the dates.

Please describe other people and/or relationships (not mentioned previously) that are a factor in your child's problems: (Ex., siblings, grandparents, in-laws, etc.)

What are your goals for your child's counseling?

Are there any symptoms that impair your ability to function effectively?

EDUCATION

Where is your child going to school? Grade: _____

Does your child have any diagnosed learning disabilities? ☐ Yes ☐ No

Does your child have an individual Educational Plan (IEP)? ☐ Yes ☐ No

Is School part of the problem? ☐ Yes ☐ No If so, please explain:

Is your child in a gifted program? ☐ Yes ☐ No Any concerns about this?

Has your child been held back a grade? ☐ Yes ☐ No If so, please explain:

Please describe any problems with school work or home work:

What sort of grades does your child typically receive?

MEDICAL HISTORY:

Primary Physician and/or Group:

Date/estimate last visit: Aware of your child's therapy? ☐ Yes ☐ No

Psychiatrist (if any):

Dat/estimate last visit: Aware of your child's therapy? ☐ Yes ☐ No

Please list any relevant medications and dosage your child is taking or has taken within the last 6 months

Name	**Dosage (amount & frequency, ex. 25mg 1x day)**	**MD prescribing**
_____	_____	_____
_____	_____	_____

_____ _____ _____

Does your child exercise regularly: ☐ Yes ☐ No If so, what type and how often?

Please describe your child's average or typical sleep pattern:

How much sleep do you get each night on the average?

Any problems with falling asleep?

Do you have a hard time waking up your child?

Does your child sleep in his or her own room? ☐ Yes ☐ No If not, where?

How much screen time does your child typically use per day?

Are there any other physical problems/illnesses that may be relevant to counseling?

Please check if you, your partner or other family member (if relevant) uses any of these excessively/abusively in your opinion (add + if you think major problem):

	Parent	Child	Family		Parent	Child	Family		Parent	Child	Family
Caffeine				Tobacco				Alcohol			
Marijuana				Narcotics				Amphetamines			
Cocaine				Hallucinogens				Pain Killers			
Other				Please describe							

Please explain how this impacts your child:

RELIGIOUS BELIEFS:

If you think your religious beliefs could be a factor in either the problem or helping with your child's counseling could you give us a brief explanation?

STRENGTHS

What are your child's strengths, abilities and interests?

Is there anything else the counselor should know that would assist in your child's treatment?