Central Florida Counseling & Psychological Services, Inc
1514 W. Main St., Leesburg, Fl 34748
(phone)352-365-6506 (fax)352-365-6596

Help Begins Here …

CONFIDENTIAL ADOLESCENT PATIENT INFORMATION (Parent to fill out)

(Please Print)
Name: _____
Child's First Middle Last Name
Address: _____
Number Street City State Zip
Mailing Address (If Different):_____
Number Street City State Zip
Child's Date of Birth____/____/_____ Age at last birthday _____ o Male o Female
Child's Social Security: #_____ - _____ - _____ Student: o Full Time o Part Time

RESPONSIBLE PERSON'S INFORMATION

(Please Print)
Name: _____
Parent or Guardian First Middle Last Name
Address: _____
Number Street City State Zip
Mailing Address (If Different):_____
Number Street City State Zip
Date of Birth____/____/_____ o Male o Female Social Security: #_____ - _____ - _____

Relationship to Patient: _____ o Custodial Parent o Legal Guardian
Responsible Person's Employer: _____ o Full Time o Part Time
Please indicate the best number to reach you May we call you: Yes or No May we leave a message: Yes or No
Home Phone: ( ) _____ Yes or No Work Phone: ( ) _____ Yes or No
Cell Phone: ( ) _____ Yes or No e-Mail _____
Referred by: _____ OK to Acknowledge Referral? Yes ___ No___

INSURANCE INFORMATION

Primary Insurance Carrier: _____Ins. Phone #: _____
Address: _____
Policy Holder Name: _____ Date of Birth:_____
Address:_____ Sex: o Male o Female
Phone: ( ) _____Work Phone: ( ) _____Cell Phone: ( ) _____
Policy/ID Number: _____ Group Number: _____
Social Security # _____-_____-_____ Employer: _____
Relationship of patient to insured: o Self o Spouse o Child o Other _____

Secondary Insurance Carrier: _____ Ins. Phone #: _____
Address _____
Policy Holder Name:_____ Date of Birth_____
Address_____ Sex: o Male o Female
Phone: ( ) _____ Work Phone: ( ) _____Cell Phone: ( ) _____
Policy/ID Number: _____ e-Mail:_____
Social Security Number: _____- _____-_____ Employer: _____
Relationship of patient to insured: o Self o Spouse o Child o Other _____

AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process all claims.
SIGNED: _____ DATE: _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to: CM Reid & Associates, Inc./Central Florida Counseling & Psychological Services, Inc.
SIGNED:_____ DATE: _____

For Office Use Only: DX _____
Managed Care: # Sessions Auth'd _____ Start _____ End _____ Auth # _____

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CONSENT FOR SERVICES

This form is to document that I, _____ _____give my permission and consent
PRINT NAME
to the above, Central Florida Counseling & Psychological Services, Inc., to provide

psychotherapeutic treatment and/or assessments to me and/or _____,
PRINT NAME
who is/are my child/children or for whom I am legal guardian, custodian, or legal Power of

Attorney.

I understand the following:

- Although I expect benefits from this treatment and/or evaluation, such benefits or particular outcomes cannot be guaranteed.
- This therapist is not providing an emergency service. In case of an emergency, please call 911or go to your nearest emergency room.
- Regular attendance will produce maximum benefits, but I am free to discontinue treatment at any time.
- Your therapist may terminate treatment for non-compliance of treatment goals, no shows, last minute cancelations, inappropriate or criminal behavior or non-payment of fees.
- We may utilize a collection service for non-payment of fees.
- Conversations with the therapist are confidential. However, by law, there are certain exceptions to the limits of confidentiality. These limits include actual or suspected child abuse, elder abuse, and threats of harm toward oneself or others. The therapist will make reasonable efforts to discuss these issues before breaking confidentiality, however disclosure may become necessary when ordered by a court of law.

I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

Signature: _____ Date: _____

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FINANCIAL AGREEMENT

As a courtesy, this office will file claims with the insurance company for you. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor/therapist. I understand that it is my responsibility to pay any deductibles, co-insurance or any other balance not paid by my insurance or third party payer within a reasonable period of time, not to exceed 60 days. Unless this office has a direct contract with your insurer, we ask that at each session you pay a deposit, $150 for an Initial Intake Assessment and a $100 deposit for each individual ($135 for couples or family) thereafter. We are contracted with Medicare and some EAP and PPO plans. Also, it is the patient's responsibility to determine if preauthorization is required. Treatment Summary Requests, Professional Letters, E-mails or Phone/Conference calls may be billed, if requested, in 15 minute increments at the individual therapeutic rate.

If you need to cancel or reschedule an appointment, please give us 24 business hours advance notice; otherwise, you could be billed at the hourly rate. If I am asked to participate in any legal proceedings on your behalf, my rates are $240 per hour with a 3 hour minimum and includes preparation, travel and testimony.

Signature(s): _____ Date: _____

COORDINATION OF TREATMENT

It is important that all healthcare providers work together. As such, I would like your permission to communicate with your Primary Care Physician and/or Psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

_____ You may inform my Physician(s). _____You may NOT inform my Physician.

Physician/Psychiatrist Name: _____

Address: _____Phone: _____

Physician/Other Name: _____

Address: _____Phone:_____

Signature(s): _____Date: _____

NOTICE OF PRIVACY PRACTICES

I have read a copy of HIPPA posted in the office. (A copy is available upon request) I may discuss any concerns about these policies with the therapist.

Signature(s): _____Date:_____

BIOLOGICAL FAMILY

Parents

Parents Marital Status: O Single O Married O Divorced O Widowed O Separated

O Cohabitating (Living together) O Other _____

Length of their relationship: _____years (s) _____months (s)

How would you describe their relationship? O Excellent O Good O Fair O Poor

Mother _____ Age _____ Father _____ Age _____

Deceased? O Yes O No Deceased? O Yes O No

If yes, cause _____ If yes, cause _____

Child's age at their death_____ Child's age at their death _____

Her occupation_____ His occupation_____

Her health _____ His health _____

How would you describe child's relationship with their mother: O Excellent O Good O Fair O Poor

How would you describe child's relationship with their father: O Excellent O Good O Fair O Poor

Other Children

***Brothers*:**

1. Name _____ Age _____ O Living O Deceased

If living, how would you describe their relationship? O Excellent O Good O Fair O Poor

2. Name _____ Age _____ O Living O Deceased

If living, how would you describe their relationship? O Excellent O Good O Fair O Poor

***Sisters*:**

1. Name _____ Age _____ O Living O Deceased

If living, how would you describe their relationship? O Excellent O Good O Fair O Poor

2. Name _____ Age _____ O Living O Deceased

If living, how would you describe their relationship? O Excellent O Good O Fair O Poor

Please include additional siblings on the back of the form

STEP FAMILY OR GUARDIANS- (If applicable)

Name	Age	Relationship	In household Yes or no	Important factors relating to child

Describe the child's ***family*** support system: _____

_____

_____

SIGNIFICANT FAMILY EVENTS

Include moves, divorces, custody issues, foster care placements, marriages, and new family members, and any event that affects the child either negatively or positively. Use the back of the page if more room is needed.

_____

_____

_____

_____

_____

_____

_____

PEER RELATIONSHIPS

Does the child seek friendships with peers?	**Yes**	**No**
Is the child sought out by peers for friendship?	**Yes**	**No**
Is the child considered a leader?	**Yes**	**No**
Is the child involved in a gang?	**Yes**	**No**
Does the child have at least one close peer relationship/friendship?	**Yes**	**No**

Describe any problems the child has with peers: _____
_____

Describe the child's ***peer*** support system: _____
_____

EDUCATIONAL ASSESSMENT

Current grade_____ Name of current school_____
Classes child gets best grades_____
Classes child gets worst grades_____
Number of different schools the child has attended _____
Reason for changes_____
Has the child ever been tested for academic or behavioral reasons? ___No ___ Yes
If yes, date when tested____
Describe any special education supports being used_____
Has the child repeated any classes? ___ No ___ Yes
If yes, list grades_____
Has the child skipped any classes? ___ No ___ Yes
If yes, list grades_____
Describe the child's ***school*** support system: _____

_____

SPIRITUAL ISSUES

Does the child attend any spiritual events regularly?	Yes	No
Does the child express concerns about death and dying?	Yes	No
Does the child express concerns about feeling guilty?	Yes	No
Does the child express concerns about love and/or hate?	Yes	No
Is it acceptable to the parent to address spiritual issues in session?	Yes	No

Describe any problems the child has with spiritual issues _____

_____

Describe the child's ***spiritual*** support system_____

_____

COMMUNITY INVOLVEMENT

Organizations that the child is involved in _____

_____ _____

_____ _____

RECREATION

List the things the child likes to do for fun _____

_____ _____

_____ _____

CHILD'S STRENGTHS

List the things you see as strength in your child _____

_____ _____

_____ _____

CHILD'S WEAKNESSES

List the things you see as weaknesses in your child _____

_____ _____

_____ _____

Please tell us why you have brought your child here today: _____

_____

_____

PROBLEM BEHAVIORS

Behaviors	**Home**	**School**	**None**	**Comments**
Angry Outbursts/Tantrums				
Arguing with adults				
Conflicts with peers/ siblings				
Difficulty completing work				
Difficulty with authority (police, teachers, etc.)				
Doesn't finish tasks				
Doesn't seem to listen when spoken to directly				
Easily distracted by outside Stimuli				
Engages in bullying or threatening behaviors				

Behaviors	Home	School	None	Comments
Fails to give close attention to school works/ makes careless mistakes				
Has used a weapon (gun, knife, broken glass, baseball bat)				
Impulsivity (responds without thinking)				
Difficulty sitting still				
Often fidgets or squirms				
Often runs or climbs excessively in situations where inappropriate				
Often talks excessively				
Multiple suspensions from school				
Physically aggressive				
Poor Grades				
Spiteful or vindictive behaviors				
Verbal Aggression (i.e. threats toward others)				
Weight loss/gain				
Defying/refusing to follow the rules or requests of adults				
Binging and/or Purging Food				
Blaming others for their own mistakes				
Changes in appetite				
Deliberately doing things that annoy others				
Depressed Mood				
Diminished interest or pleasure in previously enjoyed activities				
Fatigue or loss of energy				
Fear of social situations				
Fears (outside normal childhood fears)				
Fire-setting				
Hallucinations or Delusions				
Sleeping too much				
Inflated self-esteem				
Insomnia (problem getting to sleep or staying asleep)				
Irritability (a change from previous functioning)				
Learning Disorders -Processing Difficulties				
More talkative than usual				
Pica (eating non-food items)				
Nightmares				

	Home	School	None	Comments
Problems with boundaries with peers or adults				
Problems with speech/communication				
Restlessness or feeling keyed up				
Runaway or stayed out at night against parent's wishes				
Separation anxiety				
Somatic complaints (headaches, stomachaches)				
Tics (either motor or vocal tics)				
Excessive worry (client has difficulty controlling the worry)				
Failure to initiate or respond in a developmentally appropriate fashion to social situations				
Repetitive behaviors (e.g. hand washing, checking, counting)				
Sexually acting out behaviors				

DANGER TO SELF OR OTHERS

Behavior	No	Yes	If yes, date of event	Treatment received for event, where, inpatient, out-patient, how long, etc
Cutting				
Homicidal attempts				
Homicidal thoughts				
Overdose				
Stabbing/ Shooting				
Suicidal attempts				
Suicidal thoughts				

DEVELOPMENTAL HISTORY

List any developmental problems such as delayed speech or walking: _____

_____

_____

PHYSICAL HEALTH SCREEN

Medications- Include non-prescriptions and prescription drugs and/or supplements
If need to add more- please put on the back of this sheet

Drug & dose	Frequency	Reason given	Effectiveness & Side effects	Prescribing Doctor	Date started

	Normal	Describe any problems	Date of last exam	Doctor
Dental				
Hearing				
Ob/Gyn				
Vision				
Complete Physical				

Previous Hospitalization- Surgery- Illness (list most recent first)

Date	Illness	Hospital/Doctor

Does your child have now or in the last six months had any of the following?

Problem	No	Yes	Explanation
Anemia			
Arthritis			
Back/Neck problems			
Bleeding disorders			
Blood pressure problems			
Cancer			
Diabetes			
Dizziness/fainting			
Fractures/ dislocations			
Gastrointestinal problems			
Heart problems			
Hepatitis/Jaundice			
HIV/AIDS			
Kidney problems			
Lung problems			
Mental illness			
Nausea / Vomiting			

Over weight			
Seizures			
Severe Headaches			
Sexually Transmitted Disease			
Stroke			
Swallowing Problems			
Thyroid problems			
Tuberculosis			
Unsteady walk/falls			
Weight gain/loss			
Any other condition?			

Does your child:

Smoke? ___No __Yes Drink? ___No __Yes Use Recreational Drugs? ___No ___ Yes

FAMILY HISTORY

Family history of these illnesses /conditions with mother or father?

Illness	**No**	**Yes**	**Explain**
Asthma			
Cancer			
Diabetes			
Heart disease			
High blood pressure			
Mental illness			
Stroke			
Tobaco use			If yes: Amt /day _____ # of years ____ Have you quit? Yes or No
Alcohol use			If yes: Amt /day _____ # of years ____ Have you quit? Yes or No
Type of alcohol: Beer / Wine / Liquor			
Recreational Drugs			If yes: Amt /day _____ # of years ____ Have you quit? Yes or No
Drug(s) of choice: _____/_____/_____/_____/			
Suicide attempt and/or completetion			If yes: when