First West Counseling Center

Personal Information History for Minors

To make our first meeting productive, please give accurate responses to every section of this form. If necessary, write additional information in the margins.

Today's Date: _____

Child's Name: _____ Age: _____ D.O.B.: _____

Parent's Name: _____

Address: _____ City: _____ St.: _____ ZIP:_____

Phone: (h) _____ (w)_____ (c)_____ Best time to call:_____

Do you consent to receive automated appointment reminders? Circle one: **YES** / **NO**

If YES, circle your preferred method of contact: TEXT PHONE CALL EMAIL

Client Signature_____**Date**_____

In case of emergency, contact:_____
Relationship to client:_____
Phone number:_____

Information about your child:

Circle last year of school completed: Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12

Siblings	Age	Sex	Relationship to you:	Lives in your home:
_____	____	_____	_____	Y / N
_____	____	_____	_____	Y / N
_____	____	_____	_____	Y / N
_____	____	_____	_____	Y / N
_____	____	_____	_____	Y / N
_____	____	_____	_____	Y / N

How would you describe your child's relationship with siblings?

_____

How would you describe your child's relationship with other children outside the home?

_____

Has your child ever been to counseling for any reason? Yes___ No___

What reason? _____ How long?_____ Counselor:_____

Is your child involved in any other family counseling or support groups?

Yes _____ No_____

Specify_____

What do you want your child to gain from counseling?_____

_____

_____

What is your/your child's religious preference? _____

Church attended, if any:_____

How strong is the influence of church in your child's life?_____

Family Physician_____ Psychiatrist/Psychologist_____

Is your child currently taking any prescription drugs? Yes__ No__

If yes, state the drug name(s), type, and purpose:

_____

Who prescribed the drug(s)?_____

How often does your child see this doctor?_____

Describe your child's physical health: excellent good adequate poor

Is your child taking prescription drugs for emotional distress? Yes ___ No ___

If yes, state the drug name(s)_____

Who prescribed the drug(s)?_____

How often does your child see this doctor?_____

Has your child ever been hospitalized for mental illness or substance abuse? Yes__ No__

If yes, for what reason?_____

How long in treatment?_____

Circle any LOSSES that your child has experienced:

Father Mother Sister Brother Grandmother Grandfather Friend

Other_____

Circle any VICTIMIZATION your child has experienced or been involved with:

•Child abuse: Physical, Emotional, Sexual, Incestual • Abandonment • Rape •Robbery
•Assault •Suicide attempt • Auto or Industrial accident • Major illness • Surgery
•Physical disability • Alienation •Other_____

Circle any PROBLEM that currently concerns your child:

•Relationships with Children, Siblings, Parents, Relatives, Co-workers, Friends or Teachers
•Alcohol •Street drugs •Binge Eating •Excessive Dieting •Excessive Exercise
•Shopping •Work •Procrastination •Communication •Depression •Anger •Grief
•Gender Identity •Sex •Career •Loneliness •Mood swings •Self-esteem
•Codependency •Stress •Fear •Anxiety •Feelings about church or God
•Other_____

Underline each situation that your child is currently experiencing:

•Suicidal thoughts, plans, attempts.
•Homicidal thoughts, plans, attempts.
•Desire to cause pain to self or others.
•Fear for life or personal safety.
•Too depressed to care for self.

By signing below, I affirm that I have given permission for the assigned counselor to see my child and that the information given on this form is true and complete.

_____ _____
Custodial Parent or Guardian (PRINT) ***Date***

_____
Custodial Parent or Guardian Signature

Financial Agreement

First West Counseling Center's fees range from **$55 - $75** per session, depending on the counselor seen. Payment must be made at the time of the appointment. *FWCC does not file with insurance.*

Some of our counselors will see clients at a reduced session rate. FWCC will provide an application for financial assistance upon the counselor's consent and the client's request. The application must be completed providing all requested information and returned to the FWCC Office with proper documentation. *Approval for financial assistance is at the discretion of the FWCC Office.*

There is a nonrefundable fee of $25 for missed or canceled appointments when notification is not received at least 24 hours in advance of the scheduled appointment time.

I have read and agree to comply with the terms and conditions listed above.

Client Signature _____ Date _____

Notice of Privacy Practices Consent Form

Effective April 14, 2003, a federal regulation commonly known as "HIPPAA Privacy Rule" requires that we must provide all of our clients with a detailed notice, in writing, of our privacy practices. We have this lengthy "Notice of Privacy Practices" available upon request.

I understand that as a condition of my receiving treatment from First West Counseling Center they may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of the practice at FWCC. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me and which I have had the opportunity to review.

I understand that the privacy practices described in the Privacy Notice may change over time, and that I have a right to obtain any revised Privacy Notice.

I also understand that I have the right to request that FWCC restrict how my health information is used or disclosed. FWCC does not have to agree to my request for the restriction, but if they do agree, they are bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent in writing at any time. My revocation/withdrawal will be effective except to the extent that FWCC has taken action in reliance on my consent for use of disclosure of my health information. Provision of the future treatment may be withdrawn if I withdraw my consent.

_____ _____

Signature Date