

Healing Heart Ministry
Heather R. Hart, MS, LPC
Child & Adolescent-Client Information Form

Date: _____

Client Name: _____ Date of Birth: ____/____/____

Age of Patient: _____ Name of person completing this form _____

Relationship to Client: _____

Address: _____ City: _____ State: _____

Zip: _____ Email: _____

Home Phone#: _____ Cell# _____

Dear Parent: The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, please write on the back of the page and list the number of the question being answered. If you do not know the answer to a question please leave it blank.

I. Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.):

II. Medical History:

Name of Pediatrician or Family Doctor: _____

Date last seen: _____

Would you like our findings and recommendations sent to your pediatrician? Yes No

Please circle any of the following medical/psychological conditions for which your child was ever evaluated or diagnosed:

Seizures

Heart Problems

Weight Problems

Head Injury

Asthmatic condition

Chronic Fatigue

Chronic Headaches

Depression

Chronic Hearing Loss

Stomach Problems

Suicidal Thoughts

Surgeries

Other: _____

Please *explain* any item that you checked and list any medication(s) that were previously prescribed.

Allergies (Please list all of your child's allergies):

Current Medications (Please list all of your child's current medications other than above):

III. Past Psychiatric/Psychological History:

Has your child ever received psychiatric services or counseling? Yes No If yes, please explain and include dates of service, location, clinician's name, and medications prescribed.

IV: Developmental History:

A: Relating to your child's birth:

Your child's weight at birth: ____lbs. ____oz. Was this a full term birth? Yes No

If no, explain: _____

Did either parent use drugs or alcohol at the time of conception? Yes No

If yes, explain: _____

Were there any complications with the labor & delivery such as jaundice, infection etc.?

Yes No If yes, explain: _____

Were there any problems after birth? Yes No If yes, explain: _____

B. Pre-school/Toddler Temperament: Please circle the following items that apply.

Did not enjoy being held
Excessive restlessness
Colic

Sensitive to light / noise
/ texture
Feeding problems
Sleep problems

Head-banging
Fussy or unhappy
Difficulty bonding

C. Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:

_____ Sitting alone _____ Walking _____ Put words together _____ Toilet trained

D. Unusual behaviors/Speech patterns (circle all that apply):

Spinning
Putting things in mouth

Repeating words or
phrases inappropriately

Hand flapping
Sniffing excessively
Saying "I" for "You"

V. School/daycare History:

Did your child attend daycare? Yes No If yes, what was their age? _____

Any problems? _____

What were your child's grades on their last report card? _____

What is the name of your child's primary teacher? _____

Name of Current School _____

Dates Attended _____

Present Grade Placement _____

Behavior Problems: Yes No

Learning Problems : Yes No

Name of
Past Schools

Dates
Attended

Grade Placement

Has your child ever been:

Evaluated for a learning disability? Yes No If yes, what grade? _____

Placed in Special Education Classes? Yes No If yes, what type of class?

Tested by the school system? Yes No If yes, when? _____

Expelled or suspended? Yes No If yes, please describe: _____

Does your child have a current IEP (Individual Education Plan)? Yes No

Does your child have a current 504 plan? Yes No

VI. Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):

Has your child been: arrested? Yes No

Assigned a probation officer? Yes No If yes, their name: _____

Jailed? Yes No

Has your child ever: appeared in juvenile court? Yes No

Or other family member ever been reported to DHR? Yes No

Been assigned a DHR caseworker? Yes No

If yes, their name: _____

Ever been a victim of child physical or sexual abuse? Yes No

If you answered yes to any of these questions, please explain: _____

VII. Family Medical History:

___ Sudden death

___ Heart disease (especially dysrhythmias)

___ Diabetes mellitus

___ Obesity

___ Narrow Angle Glaucoma

___ Seizure

___ Other _____

VIII. Family Psychiatric History:

Has any member of your child's family been treated for depression, bipolar disorder, schizophrenia, anxiety, suicidal thoughts, alcohol or other drug problems, learning disabilities or ADD/ADHD, etc.? Yes No If yes, please explain: _____

IX. Social / Family History:

Biological mothers' full name: _____

Biological fathers' full name: _____

Biological parents marital status:

Married to each other

Divorced

Separated

If divorced from one another, has either remarried? Mother Yes No

Father Yes No

If the biological parents are divorced or separated, who has custody of the patient?

Type of custody? _____

Stepmothers' name: _____

Stepfathers' name: _____

List all relatives who presently live in the same household as your child (if more than 5 please list on back of this sheet):

Name - Relationship - Type of Employment / Student Grade Level

1.

2.

3.

4.

5.

Please check any of the following stressors that presently affect your child:

___ Family financial
problems

___ Abusive behavior
___ Health problems

___ Frequent change of
household

___ Family relationships

___ Employment
problems

___ frequent moves

___ Legal problems

___ School problems

___ "Other" problem

___ Child rearing problems

___ Peer relationships

___ Drug or alcohol

Please explain how any item you checked affects your child.

Reminder: Please bring a copy of any custody papers to the initial appointment.

Please check ALL of the following symptoms or thoughts that apply to you AT THIS TIME or during the past six months:

- Depressed mood
- Diminished interests or pleasure
- Sleep disturbance
- Fatigue
- Change in appetite
- Hopelessness
- Pleasure in few activities
- Weight change
- Agitation
- Excessive worry
- I feel like I am losing control.
- Irritability
- Poor Concentration
- Tension
- Feelings of panic
- Socially withdrawn
- Use of alcohol
- Use of other drugs
- Use of tobacco
- Anxiety in social settings
- Makes careless mistakes
- Does not complete tasks
- Difficulty organizing
- Forgetful
- Confusion
- Disorientation
- Compulsive checking / counting
- Indecisiveness
- People talk about me.
- Some people want to hurt me.
- I feel emotionally distant from others.
- I hear voices or sounds others do not hear.
- I see things others do not see.
- I smell things others do not smell.
- Racing thoughts
- I do risky or dangerous things.
- Little interest in sexual activity
- Sexual problems
- Gender concerns
- I don't like my body.
- Binge eating
- Self-induced vomiting
- Laxative abuse
- Excessive fasting
- Intense fear of weight gain
- Impulsive
- I think about hurting myself.
- I have tried to hurt myself.
- Sometimes I wish I were dead.
- I think about hurting someone else.
- Exposed to a significant traumatic event
- Recurrent distressing dreams

CONSENT TO TREAT A MINOR:

Parent(s) Name(s): Father _____
Mother _____ OR
Guardian(s) _____

I give permission for _____ (minor's name) to receive
counseling from _____ (Therapist Name).

Signature: _____ Date: _____
Phone: _____

Healing Heart Ministry is committed to providing the best treatment program possible for each of our individual clients. We are pleased to have the opportunity to work with you and/or your family.

A (choose at least one option) telephone, email, and/or text reminder the day before scheduled appointments is a service we can provide with your consent: **YES OR NO**. If yes, please leave a preferred telephone number that we may also leave a brief message reminding you of your appointment.

Preferred telephone number:

I have read and understand this document:

Signature:

Date:

The first session evaluation fee is \$100.00. Additional sessions fees will follow the schedule below (please circle the one appropriate to your household income level):

SCHEDULE OF FEES:

<u>60,000 and Below</u>	<u>\$70</u>
<u>61,000 - 70,000</u>	<u>\$80</u>
<u>71,000 - 90,000</u>	<u>\$90</u>
<u>91,000 - and over</u>	<u>\$100</u>

The fees are proportionate to your total family income and are payable prior to your session with the therapist..

NO SHOW AND CANCELLATION POLICY

This appointment time is reserved for you. If you must cancel your appointment, it will be necessary for you to give 24 hours notice.

- 1. Clients who forget an appointment or for some other reason do not come for an appointment and fail to give prior notice will be responsible for their full fee due on same day of Service..**
- 2. Clients who call and give less than 24 hours notice of cancellation will be responsible for 1/2 fee unless the counseling center is able to fill that hour due on same day of Service.**
- 3. Unless otherwise notified, the therapists are obligated to wait only 15 minutes for a late client.**
- 4. Your signature confirms your understanding of all these policies explained on this intake form.**

Signatures:

Date:

Date:

Limits of Confidentiality

Information discussed in counseling sessions is held confidential and will not be shared without your permission except under the following circumstances:

1. The client threatens suicide or other physical harm to self.
2. The client threatens physical harm to another individual.
3. The client is a minor under 18 years of age and reports behavior indicative of child abuse, including but not limited to physical and sexual abuse.
4. The client reports sexual exploitation by another medical or mental health professional.

State law requires that mental health professionals must report these situations to the appropriate persons and or agencies.

Records are also required to be released when a subpoena or other court order is received ordering the release of records.

Further, when consultation and/or supervision of therapy is required, counseling sessions will be discussed confidentially with a supervisor or professional colleague as deemed necessary.

Communication between the counselor and the client will otherwise be deemed confidential as stated by the laws of the state of Alabama.

Having read and understood the above, I agree to these limits of confidentiality.

Client/Parent/Legal Guardian

Date

Client/Parent/Legal Guardian

Date

Counselor

Date

NOTICE OF PRIVACY PRACTICES

This notice describes how your personal health information (PHI) may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

- Request and receive a copy of your paper or electronic treatment record (appropriate fees may apply).
- Request confidential communication: *You must sign a Release of Information Form in order for us to communicate with friends, family, coworkers, attorneys, etc.*
- Ask us to limit the information we share: *You may specify your requests on a Release of Information Form.*
- Pay full price for your therapy and request that your counselor keep session notes and diagnoses private from your health insurance provider.
- Get a list of those with whom we've shared your information.
- Get a copy of this privacy notice,
- File a complaint if you believe your privacy rights have been violated.
 - If you feel we have violated your rights, your complaint should be addressed to Heather Hart, MS, LPC at healingheartministry@hotmail.com.
 - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights
 - We will not retaliate against you for filing a complaint.

OUR USES AND DISCLOSURES

We may use and share your information as we:

- **Treat you:** *We may obtain records from other medical or mental health professionals that you have previously seen.*
- **Run our organization:** *directors, office managers, and business associates may access your information in order to collect payment, schedule appointments, or communicate with you or those you give us permission to contact.*
- **Bill for your services:** *Business Associates of Healing Heart Ministry or your counselor may contact your health insurance provider or a designated payer to obtain payment for services*
- **Comply with the law:** **We are required to report suspected abuse, neglect, or intent to harm self or others.**
- **Address law enforcement and other government requests**
- **Respond to illegal behavior, lawsuits, and legal actions:** *We are required to respond to court orders by providing session notes and by possibly testifying in court. We will contact local authorities should illegal activity occur on our premises.*

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information. We will never disclose your PHI for marketing or fundraising activities: *All counselors and business associates of Healing Heart Ministry utilize HIPAA- compliant electronic communication services. All paper and digital PHI records are stored, secured, and disposed of as outlined in HIPAA guidelines.*
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECEIPT

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge the receipt of the Notice of Privacy Practices of Healing Heart Ministry and your counselor. This Notice of Privacy Practices provides information about how HHM and all HHM business associates may use and disclose your protected health information. We encourage you to read it in full.

This Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Healing Heart Ministry at healingheartministry@hotmail.com.

If you have any questions about our Notice of Privacy Practices, please contact:
Heather Hart, MS, LPC at healingheartministry@hotmail.com.

I acknowledge the receipt of the Notice of Privacy Practices of Healing Heart Ministry.

Client's Name: _____

Signature: _____ Date: _____

(client/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT
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Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Client's Name: _____

Reasons why the acknowledgement was not obtained:

- Client refused to sign this acknowledgement even though the client was asked to do so and was given the Notice of Privacy Practices.

- Other:

Signature of provider representative: _____

Date: _____