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	Asthmatic condition	Stomach Problems
Heart Problems	Chronic Fatigue	Suicidal Thoughts
Weight Problems	Chronic Headaches	Surgeries
Head Injury	Depression	Other: _____
	Chronic Hearing Loss	

_

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	Sensitive to light / noise	Head-banging
Excessive restlessness	/ texture	Fussy or unhappy
Colic	Feeding problems	Difficulty bonding
	Sleep problems	

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	Repeating words or	Hand flapping
Putting things in mouth	phrases inappropriately	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
___ Family relationships
___ Legal problems
___ Child rearing problems
___ Drug or alcohol
___ Abusive behavior
___ Health problems
___ Employment problems
___ School problems
___ Peer relationships
___ Frequent change of household
___ frequent moves
___ "Other" problem
_____

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:

60,000 and Below	**$70**
61,000 - 70,000	**$80**
71,000 - 90,000	**$90**
91,000 - and over	**$100**

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 the date of missed appointment.

2. Unless otherwise notified, the therapists are obligated to wait only 15 minutes for a late client.

3. Your signature confirms your understanding of all these policies explained on this intake form.

Signatures:

_____ **Date:** _____

_____ **Date:** _____

Healing Heart Ministry

Client Contract and Disclosure Statement

Your therapist is a Christian Counselor with experience in individual, marriage, family, and group counseling. She is a licensed counselor in the State of Alabama and has earned a Masters Degree.

Counseling requires effort on the part of the client. Homework will be decided on collaboratively between the client and the counselor and will be determined by the nature of the presenting problem(s). Clients are expected to show up for scheduled sessions, pay for scheduled sessions in a timely manner, do homework, and keep the identity of other clients confidential. *Clients are responsible for the session fee if insurance company does not pay.*

Your therapist's responsibility is to keep confidences as prescribed by law, not share any information that is learned through counseling unless someone is going to harm him/her self, someone is going to harm someone else, and if a child is being abused, and/or required by law. All records are confidential and clients must sign a release before case information can be given to anyone. In marriage and family counseling, the release must be signed by **ALL** family members involved. Your therapist does not provide expert testimony in court proceedings. If required by law to testify, she will testify only to the process and content of therapy as prescribed by law.

As a service to the community, Healing Heart Ministry provides professional counseling at a reduced fee compared with other agencies and private practitioners**. The initial fee is $100.00.**

Please let us know whom we can thank for your referral:

_____ Or

Internet Yellow Pages/Phone Book Church/Pastor

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

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:_____