

**CONFIDENTIAL CHILD/TEEN QUESTIONNAIRE**  
Debra Gipple, M.A., LMHC

**CHILD/TEEN PERSONAL INFORMATION**

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date: \_\_\_\_\_  
Street, City, ZIP: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_

Circle one: Biological    Half    Step    Adopted    Foster    May we leave a message at home? Yes    No

Mother's name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Place of employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ May we leave a message at work? Yes    No  
Stepmother's name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Place of employment: \_\_\_\_\_

Father's name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Place of employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ May we leave a message at work? Yes    No  
Stepfather's name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Place of employment: \_\_\_\_\_

Referred to Family Legacy by: \_\_\_\_\_

**SIBLING INFORMATION**

First Name	Last Name	Age	Biological	Half	Step	Adopted	Foster

Child's/Teen's Physician \_\_\_\_\_ Phone number: \_\_\_\_\_

1. Is the child/teen **currently** under the care of a Doctor/Psychiatrist/Counselor/Psychologist? Yes    No  
If yes, whom? \_\_\_\_\_  
General nature of care/counseling? \_\_\_\_\_
2. Has the child seen a Psychiatrist/Counselor/Psychologist **in the past**? Yes    No  
If yes, whom? \_\_\_\_\_  
Dates of past counseling? \_\_\_\_\_ General nature of past counseling? \_\_\_\_\_
3. Is the child/teen **currently** taking any medication? Yes    No  
If yes, what kind(s) and dosage(s)? \_\_\_\_\_  
Who is the prescribing physician? \_\_\_\_\_
4. Does the child/teen have any allergies? Yes    No    If so, what type? \_\_\_\_\_  
If yes, what treatment? \_\_\_\_\_
5. Does the child/teen have any food allergies or sensitivities? Yes    No    If so, what type? \_\_\_\_\_
6. What are the child's/teen's interests, hobbies, or activities? \_\_\_\_\_  
\_\_\_\_\_
7. Reason(s) for seeking counseling? \_\_\_\_\_
8. Please explain any special needs your child/teen has (i.e. physical, educational, speech, developmental, etc.):  
\_\_\_\_\_
9. Church affiliation, if any \_\_\_\_\_

## INFORMED CONSENT

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Thank you for choosing Family Legacy Counseling to help you with your concerns. Our experience includes, but is not limited to, adult and child therapy, marriage and family counseling, pastoral counseling, abuse recovery, divorce recovery, substance abuse, eating disorders, and life stage issues.

**Treatment:** We believe counseling is a process whereby a client seeks to resolve interpersonal, emotional, and/or spiritual difficulties with the assistance of a therapist. Your therapist will bring professional knowledge and experience to each session, but the ultimate responsibility for growth and changes rest with you and your child, the client. Therapy can last from a few weeks to several months. The therapist will have ongoing dialogue with you about your needs or your child's needs, progress, and recommendation of the duration of therapy. You are invited to ask questions about your therapist's methods or direction at any time. If for any reason you are dissatisfied with your therapist, please let him or her know so that an attempt can be made to resolve your concerns. If your therapist is unable to resolve your concerns, he or she will assist you in finding qualified help elsewhere. If the therapist believes that outside involvement is necessary or another counselor at Family Legacy would be helpful, it will be recommended to you. You have the right to request and receive a second opinion at any time. Occasionally, the therapist may elect to discontinue therapy. This usually happens when they feel no substantial progress is being made or other factors are interfering with their ability to help you.

Counseling can be a disruptive process as you seek to create the change in your life that you desire, and it is possible that you may at times become depressed, anxious, agitated, or feel some other emotional/physical discomfort as you proceed through this process. You will always be free to move at your own pace, and talk with your therapist about any of these kinds of things that you may experience. It is also important for you to understand that your therapist cannot offer any promise about the results you will experience. Your outcome will depend upon many things... some that are beyond the therapist's control.

**Fees:** A clinical hour is 50 minutes. Our counseling sessions are normally for that amount of time. Payment is expected before your session begins. The fee for the first session is \$150.00 and \$110.00 for sessions thereafter. If your account shows a balance of \$200.00, services will be suspended until the balance is brought up to date. **Please initial \_\_\_\_\_**. A processing fee of \$10.00 will be added to those accounts that require a statement to be sent for unpaid balances. By maintaining a zero balance on your account for co-pays, private pay, testing or other fees you will be able to avoid the processing fee. This excludes billed insurance balances. **Please initial \_\_\_\_\_** .

**Insurance:** We do have some therapists that are covered under Wellmark and United Healthcare Insurance. We will submit claims for you if you have coverage under either of them. If you have coverage under another insurance carrier, we can supply you with a receipt that you can submit for reimbursement. Please note that once we submit to insurance or supply you with a receipt, the insurance company can require the disclosure of confidential information in order to process claims. Submitting a mental health claim carries a risk to confidentiality, privacy, and/or to future eligibility to obtain health or life insurance. In many cases, your

insurance company must approve all sessions in advance. If for any reason your insurance company does not pay the claims, you will be responsible for paying the fee for counseling. **Please initial \_\_\_\_\_.**

**Cancellations:** Your therapist has reserved your appointment time expressly for you. Since there is often a waiting list, we require twenty-four hours notice prior to your scheduled appointment for cancellations. If you do not show up for your appointment or fail to give 24 hours notice, you may be charged half the session fee, or \$55.00, for the missed session. We understand that emergencies do arise. If this is the case, please call the office as soon as possible. **Please initial \_\_\_\_\_.**

**Office Hours and Emergencies:** Our scheduled days are Monday through Friday. Each therapist has set hours and can discuss this with you when trying to find a time and day that works best for you. Our phones are answered Monday through Friday 8:00AM to 4:00PM. Voice mail is available after office hours and is confidential, so please feel free to leave a message. Voice mail will also instruct you how to reach your therapist in case of an after hours emergency.

**Confidentiality:** All counseling is confidential, according to the Code of Ethics adhered to by your therapist. Your therapist may consult with other professionals regarding situations to gain other perspectives and ideas as how to best help you reach your goals. Such consultations are obtained in a way that complete confidentiality is maintained. If you choose to have us share information with another individual, we will request that you sign a release of information. Once information is shared we can not guarantee your confidentiality. The therapists at Family Legacy are required by State Law, Code Section 232 and 235, to report suspected incidences of child, or dependent, or elder abuse. If your therapist believes there is a risk that you might harm yourself or someone else, he/she will be required to contact the authorities, a family member or friend, or the person being threatened to give them the opportunity to protect you and/or him/herself.

**E-Mails:** It is important to be aware that email, cell phone or fax communication can be accessed by unauthorized people, and therefore, the privacy and confidentiality of such communication can be compromised, and, therefore, cannot be guaranteed. If your electronic communication is not responded to in a reasonable amount of time, please follow up with a phone call to ensure your communication was received.

**Litigation Limitation:** Neither I nor my attorney, nor anyone else acting on my behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the therapy notes be requested. **Please initial \_\_\_\_\_.**

**Notice of Privacy Rights:** I have read Family Legacy Counseling Notice of Privacy Rights.

*I/we have read, understand, and agree to comply with the policies and information presented above. My/our signature (s) below indicate my/our intention to enter into a counseling relationship, and indicate that I/we do so with informed consent.*

Name of Child/Teen \_\_\_\_\_

Signature of Parent/Legal Gaurdian \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_