

Anne J. Ford MSW, LICSW

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CONSENT FOR TREATMENT OF A MINOR
(Ages 13-18)

I agree to therapeutic services provided to my minor child by Anne Ford, LICSW at this office.

Client's name _____

Address _____

Parent(s)/Guardian(s) Signature _____

Address (if different than client's address)

Date _____

I/we understand that I/we have the right to information concerning my minor child in therapy, except where otherwise stated by law. (Minnesota Stat 144.341-342 except when the minor is married, legally emancipated or has borne a child, or when information in the records concern venereal disease, chemical dependency, or pregnancy related conditions. Minnesota Statute 144.343)

I also understand that this therapist believes in providing a minor child with privacy in which to disclose her/himself to facilitate therapy. I therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed to my child is to be shared with me. (Minnesota Statute 144.335 subd 2)

Parent(s)/Guardian(s) signature _____

Date _____

Adolescent Intake Form

Today's Date:

Child's Name: (First, M.I., Last)		Birthdate:	Age:
Father's Work Phone:		Mother's Work Phone:	Sex:
Home Phone:		Home Phone:	M F
Father's Name:	Age:	Occupation:	Education Level:
Mother's Name:	Age:	Occupation:	Education Level:
Legal Guardian:		Child currently lives with:	
Step-Parent(s) (if applicable):		Child Telephone and Address (if different):	

Name of person completing form

Please give a brief description of why you are seeking treatment:

Who referred you to our clinic?

1. FAMILY AND SOCIAL HISTORY

Child's Siblings:	Age:	Sex:	At Home?	Child's Siblings:	Age:	Sex:	At Home?
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Is your child or any siblings adopted?

List anyone else living in the household?

If applicable, give date(s) child/adolescent's of parent's marriage, separation(s) and divorce:

FAMILY AND SOCIAL HISTORY (CONTINUED)

Comments about custody/visitation (if applicable)

Describe any family history of mental health or chemical dependency problems or treatment:

Is child presently in any childcare setting? Yes No N/A

If yes, how many hours?

Where?

List any involvement with social services, child protection, the court system or legal services:

Has your child ever been hurt as listed below? Yes No

If yes, please circle: Physically Emotionally Sexually By ways of neglect

Has your child ever witnessed physical violence?

What major stresses or changes have occurred in your child's life?

Who does your child regard as the most supportive person in their life (specific family members, teacher, coach, friends, pets, etc.):

2. SCHOOL HISTORY

Name of current school:

Grade:

Teacher's Name:

List any special services received through the school system and grade level child received services:

Does your child have behavior or social problems at school (or day care)?

Is your child employed outside of the home? Yes No How many hours per week?

3. DEVELOPMENTAL HISTORY

Were there any problems during pregnancy, labor, birth or delivery with this child? Yes No

If yes, please give details:

DEVELOPMENTAL HISTORY (CONTINUED)

Was there any use of drugs, alcohol or nicotine during the pregnancy?

Have there been any concerns or delays with your development in any of the following areas? If yes, please indicate who evaluated the problem if help was sought:

	Yes	No	Evaluated by:
1. Speech and language	Yes	No	_____
2. Hearing	Yes	No	_____
3. Vision	Yes	No	_____
4. Intelligence/ability to learn	Yes	No	_____
5. Bladder/Bowel Control	Yes	No	_____
6. Emotional/Maturity Level	Yes	No	_____
7. Social Skills	Yes	No	_____
8. Eating Habits	Yes	No	_____
9. Fine Motor Skills (writing/coloring/etc.)	Yes	No	_____
10. Gross Motor Skills (walking, running, etc.)	Yes	No	_____

4. MEDICAL HISTORY

Primary Care Clinic:

Physician:

Date of last medical examination:

List any current medical problems:

List any hospitalizations or serious medical problems:

List any medication currently taking:

List any previous medications taken for psychological reasons, and whether or not they were helpful:

List any drug allergies:

List any other allergies:

Has your child had any pregnancies, miscarriages, abortions?

Does your child use any over-the-counter medications regularly/frequently?

Does your child have any communicable diseases? Yes No
Type (such as tuberculosis)

5. CHEMICAL USE HISTORY – Child and Adolescent Youth

Is your child's use of drugs or alcohol concern? Yes No if so, please check those that apply:

Alcohol_____ Amphetamines_____ Tranquilizers_____ Narcotics_____
Marijuana_____ Other_____

CHEMICAL USE HISTORY – Child and Adolescent Youth (CONTINUED)

Has your child used more than one chemical at the same time in order to get high? Yes No

Does your child avoid family activities so s/he can use? Yes No

Does your child have a group of friends who also use? Yes No

Do you think your child uses is/her emotions such as when feeling sad or depressed? Yes No

Does your child use tobacco products? Yes No If yes, type?
Quantity per day?

Does your child use caffeine? Yes No If yes, type?
Quantity per day?

6. PREVIOUS HISTORY

List any counselors seen in the past and reason for visits:

List dates of any psychiatric hospitalizations:

7. OTHER

What are your child's strong points?

Is spirituality and/or faith system important in your family? To your child?

Please list hobbies, sports, clubs, or other activities that your child is involved in:

Additional comments:

Parent Signature

**Note: two forms are provided. If you feel your child is able,
please have him or her complete one form.**

Please check the symptoms that are of concern:

0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

- | | |
|--|---|
| <p>0 ___ 1 ___ 2 ___ Feeling down or depressed</p> <p>0 ___ 1 ___ 2 ___ Problems with sleep</p> <p>0 ___ 1 ___ 2 ___ Sometimes wishing not to be alive</p> <p>0 ___ 1 ___ 2 ___ Suicidal thoughts</p> <p>0 ___ 1 ___ 2 ___ Doing things to harm self</p> <p>0 ___ 1 ___ 2 ___ Crying easily or uncontrollably</p> <p>0 ___ 1 ___ 2 ___ Problems with concentration</p> <p>0 ___ 1 ___ 2 ___ Tired, not motivated</p> <p>0 ___ 1 ___ 2 ___ Thoughts about harming others</p> <p>0 ___ 1 ___ 2 ___ Irritable, angry feelings, crabby</p>
<p>0 ___ 1 ___ 2 ___ Difficulty concentrating</p> <p>0 ___ 1 ___ 2 ___ Disorganized</p> <p>0 ___ 1 ___ 2 ___ Can't sit still, restless</p> <p>0 ___ 1 ___ 2 ___ Easily distracted</p> <p>0 ___ 1 ___ 2 ___ Over active</p> <p>0 ___ 1 ___ 2 ___ Acts without thinking</p> <p>0 ___ 1 ___ 2 ___ Difficulty following though</p>
<p>0 ___ 1 ___ 2 ___ Guilty feelings</p> <p>0 ___ 1 ___ 2 ___ Nervous</p> <p>0 ___ 1 ___ 2 ___ Shy or timid</p> <p>0 ___ 1 ___ 2 ___ Frequent worry</p> <p>0 ___ 1 ___ 2 ___ Intense overwhelming feeling (panic)</p> <p>0 ___ 1 ___ 2 ___ Intense fears</p> <p>0 ___ 1 ___ 2 ___ Stomachaches</p> <p>0 ___ 1 ___ 2 ___ Headaches</p> <p>0 ___ 1 ___ 2 ___ Perfectionist</p>
<p>0 ___ 1 ___ 2 ___ Other</p> | <p>0 ___ 1 ___ 2 ___ Wetting the bed at night</p> <p>0 ___ 1 ___ 2 ___ Wetting during the day</p> <p>0 ___ 1 ___ 2 ___ Soiling</p> <p>0 ___ 1 ___ 2 ___ Family problems</p> <p>0 ___ 1 ___ 2 ___ Problems with friends</p> <p>0 ___ 1 ___ 2 ___ School Difficulty</p> <p>0 ___ 1 ___ 2 ___ Grades</p> <p>0 ___ 1 ___ 2 ___ Behavior</p> <p>0 ___ 1 ___ 2 ___ Social problems</p> <p>0 ___ 1 ___ 2 ___ Not doing homework</p>
<p>0 ___ 1 ___ 2 ___ Threatening or fighting</p> <p>0 ___ 1 ___ 2 ___ Running away</p> <p>0 ___ 1 ___ 2 ___ Lying, stealing, destructive behavior</p> <p>0 ___ 1 ___ 2 ___ Trouble with the law</p> <p>0 ___ 1 ___ 2 ___ Disrespectful or angry with adults</p> <p>0 ___ 1 ___ 2 ___ Argues</p> <p>0 ___ 1 ___ 2 ___ Defiant</p>
<p>0 ___ 1 ___ 2 ___ Strange or troubling thoughts</p> <p>0 ___ 1 ___ 2 ___ Nightmares</p> <p>0 ___ 1 ___ 2 ___ Not able to stand up for self</p> <p>0 ___ 1 ___ 2 ___ Feel unnoticed</p> <p>0 ___ 1 ___ 2 ___ Concerns about eating/body image</p> <p>0 ___ 1 ___ 2 ___ Weight changes</p> <p>0 ___ 1 ___ 2 ___ Change in appetite (more or less hungry)</p> <p>0 ___ 1 ___ 2 ___ Concerns regarding sexual behavior</p> |
|--|---|

Name of Child

Date

Name of Person Filling Out Checklist

**Note: two forms are provided. If you feel your child is able,
please have him or her complete one form.**

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0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

- | | |
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|--|---|

Name of Child

Date

Name of Person Filling Out Checklist