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CONSENT FOR TREATMENT OF A MINOR

(Ages 5-12)

I agree to therapeutic services provided to my minor child by Anne J 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 herself/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 by my child is to be shared with me. (Minnesota Statute 144.335 subd 2)

Parent(s)/Guardian(s) Signature _____

Date _____ 2

CHILD DEVELOPMENTAL HISTORY

IDENTIFYING INFORMATION

Name of Child _____ Sex (M) (F)

Birth Date _____ Place of Birth _____ Age _____

Address (number and street) _____

(City) _____ (State) _____ (Zip Code) _____

Telephone _____ Religion (optional) _____

Education (grade) _____ Present School _____

Referral Source _____

With whom does child live? _____

If parents are divorced, who has physical custody of child? _____

CHIEF COMPLAINTS:

Presenting Problems (check all that apply):

- Very unhappy** **Impulsive** **Fire setting** **Irritable** **Stubborn** **Stealing**
- Temper outburst** **Disobedient** **Lying**
- Withdrawn** **Infantile** **Sexual trouble**

Daydreaming **Mean to others** **School performance**

Fearful **Destructive** **Truancy**

Clumsy **Trouble with the law** **Bed wetting**

Overactive **Running away** **Soiled pants**

- Slow** **Self-mutilating** **Eating problems**
- Short attention span** **Head banging** **Sleeping problems**
- Distractible** **Rocking** **Sickly**
- Lacks initiative** **Shy** **Drug use**
- Undependable** **Strange behavior** **Alcohol use**
- Peer conflict** **Strange thoughts** **Suicide talk**
- Phobic** **Other (Explain)** _____

How long have these problems occurred (number of weeks, months, years)? _____

What happened that makes you seek help at this time?

Problems perceived to be: **very serious** **serious** **not serious**

What are your expectations of your child?

What changes would you like to see in your child?

What changes would you like to see in yourself?

What changes would you like to see in your family?

CURRENT FAMILY SITUATION

Mother—Relationship to Child natural parent relative
 step parent adoptive parent

Occupation _____

Education _____ **Religion** _____

Birthplace _____ **Birthdate** _____

Age _____

Father—Relationship to Child natural parent relative

step parent adoptive parent

Occupation _____

Education _____ **Religion** _____

Birthplace _____ **Birthdate** _____

Age _____

Marital History of Parents

Natural Parents: married when _____ age _____

separated when _____ age _____

divorced when _____ age _____

deceased M or F _____

Step Parents: married when _____

If child is adopted:

Adoption

source: _____

Reason and circumstances:

Age when child first in home: _____ **Date of legal adoption:** _____

What has the child been

told: _____

LIVING ARRANGEMENTS Places Dates

Number of moves in child's life _____

Present Home renting buying house apartment

Does the child share a room with anyone else? Yes No

If yes, with whom?

If no, how long has he/she had own room?

Was the child ever placed, boarded, or living away from the family? Yes No

Explain:

What are the major family stresses at the present time, if any?

BROTHERS AND SISTERS (Indicate if step-brothers or step-sisters):

Living Use drugs Treated for

School or Present at home or alcohol drug abuse

Name Age Sex Occupation Grade (yes or no) (yes or no) (yes or no)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Others living in the home (and their relationship):

1. _____
2. _____

HEALTH OF FAMILY MEMBERS (excluding patient):

Relationship Type of When Length of

Name to child Illness Occurred Illness

1. _____
2. _____
3. _____
4. _____

Does or did any member of the child's family have any problems with:

reading spelling math speech

(If yes, please explain): _____

Is there any history in the child's family of:

mental retardation epilepsy birth defects schizophrenia

CHILD HEALTH INFORMATION

Note all health problems that child has had or has now

AGE AGE

High fevers _____ Dental problems _____

Pneumonia _____ Weight problems _____

Flu _____ Allergies _____

Encephalitis _____ Skin problems _____

Meningitis _____ Asthma _____

Convulsions _____ Headaches _____

Unconsciousness _____ Stomach Problems _____

Concussions _____ Accident prone _____

Head injury _____ Anemia _____

Fainting _____ High or low blood pressure _____

Dizziness _____ Sinus problems _____

Tonsils out _____ Heart problems _____

Vision problems _____ Hyperactivity _____

Hearing problems _____ Other illnesses (explain) _____

Earaches _____

Has the child ever been hospitalized? Yes No

If yes, please

explain: _____

Age _____ How long _____

Reason _____

Has the child ever taken, or is he/she presenting taking any prescribed medications? Yes No

Please list medications

_____ Age _____ How long _____

Reason _____

Name of Primary Care

Physician: _____

Address _____

Phone _____

DEVELOPMENTAL HISTORY

Pre-natal—Child wanted? Yes No Planned for? Yes No

Normal pregnancy? Yes No 6

If mother ill or upset during pregnancy, please explain: _____

Length of pregnancy: _____

Parental support and acceptance (please explain): _____

BIRTH

Length of active labor: _____ hours Easy Difficult

Full term: Yes No

If premature, how early: _____

If overdue, how late: _____

Birth weight: _____ lbs. _____ oz.

Type of delivery: spontaneous cesarean with instruments

head first breech

Was it necessary to give the infant oxygen: Yes No If yes, how long: _____

Did infant require blood transfusions: Yes No

Did infant require X-ray? Yes No

Physical condition of infant at

birth: _____

Did mother abuse alcohol/drugs during pregnancy? Yes No

NEWBORN PERIOD

How long?

Irritability Yes No _____

Vomiting Yes No _____

Difficulty Breathing Yes No _____

Difficulty Sleeping Yes No _____

Convulsions/Twitching Yes No _____

Colic Yes No _____

Normal Weight Gain Yes No _____

Was Child Breast Fed? Yes No _____

DEVELOPMENTAL MILESTONES

Age at which child:

Sat up: _____ Crawled: _____

Walked: _____ Spoke single words: _____

Spoke sentences: _____ Bladder trained: _____ 7

Bowel trained: _____ Weaned: _____
Describe manner in which toilet training was
accomplished: _____

EARLY SOCIAL DEVELOPMENT

Relationship to siblings and peers:

- individual play group play
 competitive cooperative
 leadership role a follower

Describe special habits, fears, or idiosyncrasies of the
child: _____

EDUCATIONAL HISTORY

Name of school City/State Dates Attended Grades Completed

From To

preschool _____

elementary _____

middle school _____

high school _____

Types of class: regular learning disability gifted

emotionally handicapped other

Did child skip a grade: Yes No Repeat a grade? Yes No

(If yes, when and how many years? Appropriate grade level at present
time?) _____

Did child have any specific learning disabilities? Yes No

Please describe

Has child ever had a tutor or other special help with school work? Yes No

Does child attend school on a regular basis? Yes No

Does child appear motivated for school? Yes No

Has child ever been suspended or expelled from school? Yes No

ACADEMIC PERFORMANCE

Highest grade on last report

card? _____

Lowest grade on last report

card? _____ 8

Favorite subject? _____

Least favorite subject? _____

Does child participate in extracurricular activities? Yes No

Please describe

In school, how many friends does child have: a lot a few none

What are child's educational aspirations? Quit school

Graduate from high school

Go to school

Has child had special testing in school? (If yes, what were the results?)

Psychological Yes No **Vocational** Yes No

List child's special interests, hobbies,

skills: _____

Has the child ever had difficulty with the police? Yes No **(If yes, please explain)**

Has the child ever appeared in juvenile court? Yes No **(If yes, please explain)**

Has the child ever been on probation? Yes No **(If yes, please explain)**

ADDITIONAL COMMENTS