

Harriet Kohen, MA, MSW
Licensed Independent Clinical Social Worker
Partners in Healing of Minneapolis
10201 Wayzata Blvd. #350
Minnetonka, MN 55305
763.546.5797

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

I agree to therapeutic services provided to my minor child by Harriet Kohen, 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:
Mother's Work Phone: Home Phone:		Father's Work Phone: Home Phone:		Sex: 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:

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 _____

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 through</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 worried</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 style="padding-left: 40px;">0 1 2 grades</p> <p style="padding-left: 40px;">0 1 2 behavior</p> <p style="padding-left: 40px;">0 1 2 social problems</p> <p style="padding-left: 40px;">0 1 2 not doing home work</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 Disrespected 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

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