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CONSENT FOR TREATMENT OF A MINOR
(Ages 5-12)

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 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 _____

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):

- | | | |
|--|---|--|
| <input type="checkbox"/> Very unhappy | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Fire setting |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Temper outburst | <input type="checkbox"/> Disobedient | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Infantile | <input type="checkbox"/> Sexual trouble |
| <input type="checkbox"/> Daydreaming | <input type="checkbox"/> Mean to others | <input type="checkbox"/> School performance |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Destructive | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Trouble with the law | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Running away | <input type="checkbox"/> Soiled pants |
| <input type="checkbox"/> Slow | <input type="checkbox"/> Self-mutilating | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Head banging | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Rocking | <input type="checkbox"/> Sickly |
| <input type="checkbox"/> Lacks initiative | <input type="checkbox"/> Shy | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Undependable | <input type="checkbox"/> Strange behavior | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Peer conflict | <input type="checkbox"/> Strange thoughts | <input type="checkbox"/> Suicide talk |
| <input type="checkbox"/> Phobic | <input type="checkbox"/> 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
- step parent

- relative
- adoptive parent

Occupation _____

Education _____

Birthplace _____

Age _____

Religion _____

Birthdate _____

Father—Relationship to Child

- natural parent
- step parent

- relative
- adoptive parent

Occupation _____

Education _____

Birthplace _____

Age _____

Religion _____

Birthdate _____

Marital History of Parents

Natural Parents:

- married
- separated
- divorced
- deceased

when _____ age _____

when _____ age _____

when _____ age _____

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

Number of moves in child's life _____

Places

Dates

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):

Name	Age	Sex	School or Occupation	Present Grade	Living at home (yes or no)	Use drugs or alcohol (yes or no)	Treated for drug abuse (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):

Name	Relationship to child	Type of Illness	When Occurred	Length of 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
<input type="checkbox"/> High fevers	_____	<input type="checkbox"/> Dental problems	_____
<input type="checkbox"/> Pneumonia	_____	<input type="checkbox"/> Weight problems	_____
<input type="checkbox"/> Flu	_____	<input type="checkbox"/> Allergies	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Skin problems	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Convulsions	_____	<input type="checkbox"/> Headaches	_____
<input type="checkbox"/> Unconsciousness	_____	<input type="checkbox"/> Stomach Problems	_____
<input type="checkbox"/> Concussions	_____	<input type="checkbox"/> Accident prone	_____
<input type="checkbox"/> Head injury	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Fainting	_____	<input type="checkbox"/> High or low blood pressure	_____
<input type="checkbox"/> Dizziness	_____	<input type="checkbox"/> Sinus problems	_____
<input type="checkbox"/> Tonsils out	_____	<input type="checkbox"/> Heart problems	_____
<input type="checkbox"/> Vision problems	_____	<input type="checkbox"/> Hyperactivity	_____
<input type="checkbox"/> Hearing problems	_____	<input type="checkbox"/> Other illnesses (explain)	_____
<input type="checkbox"/> 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

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

Irritability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How long?
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Difficulty Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Difficulty Sleeping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Convulsions/Twitching	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Colic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Normal Weight Gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Was Child Breast Fed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

DEVELOPMENTAL MILESTONES

Age at which child:

Sat up: _____

Crawled: _____

Walked: _____

Spoke single words: _____

Spoke sentences: _____

Bladder trained: _____

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? _____

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