Child/Minor Information & Informed Consent

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3160 Camino del Rio S #304
San Diego, CA 92108
T 619-819-0283
F 619-819-_____
www.potentiatherapy.com

Client Name (Last, First)_____

Date of Birth _____ Age _____ Gender: Male/Female

Ethnicity _____

Name of School _____ Grade Level _____

Name of Teacher _____

School Address _____

School Phone _____

Child's Address _____

City _____ State _____ Zip Code _____

Child's Mailing Address _____

City _____ State _____ Zip Code _____

Primary Home Phone _____

Cell Phone _____

Primary household (anyone currently living with the child)

Name	Age	Gender	Relationship to child

Has your child ever seen a mental health professional (psychiatrist, psychologist, or counselor)? Yes / No

If so, when? _____

Why?_____

Is your child currently taking any medication? Yes / No

If yes, explain _____

Custody status of child (if applicable) _____

Religious affiliation of child _____

Are both parents aware minor has been brought in for counseling? Yes / No

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Check any that apply to your child, and circle those that are the most significant:

__Adjustments (Changing schools, parent's getting married or divorced, pet died, etc)
__Bed wetting
__Physical disability
__Chronic illness
__Terminal illness
__Learning disability
__Sadness or depressive symptoms
__Anxiety symptoms
__Anger or irritability
__Changes in mood
__Abuse
__Sleeping difficulties
__Obsessive
__Addictions
__ADHD symptoms
__Nightmares
__Eating problem
__Religious concerns
__Career decisions
__Personal growth
__Suicidal thinking
__Sexual concerns
__Learning/academic difficulties
__Speech problem
__Lying
__Worry
__Parent-child relationship problem
__Non-family relationship problem (teacher, peers, etc.)
__Health concerns (i.e. physical complaints)
__Other

Further description of above or any other concerns (optional):

_____

_____

In case of an emergency, contact:

Name_____ Relationship to Minor_____

Phone _____

Can messages be left on answering machines? Yes / No

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Mother Information

Mother's name (last, first) _____

I am: Biological Mother / Stepmother / Adopted Mother / Other

Age _____ Date of Birth _____

Address (Same as above) _____

Home phone _____ Work _____

Cell _____

Can messages be left on answering machines? Yes / No

Marital status: Married / Remarried / Single Parent / Widow(er) / Divorced/Separated

Religious affiliation _____

History of learning, emotional, or behavioral difficulties? Yes / No

If yes, please describe _____

History of alcohol/drug/substance use, family violence, or criminal activity? Yes / No

If yes, please describe _____

Father Information

Father's name (last, first) _____

I am: Biological Father / Stepfather / Adopted Father / Other

Age _____ Date of Birth _____

Address (Same as above) _____

Home phone _____ Work _____

Cell _____

Can messages be left on answering machines? Yes / No

Marital status: Married / Remarried / Single Parent / Widow(er) / Divorced/Separated

Religious affiliation _____

History of learning, emotional, or behavioral difficulties? Yes / No

If yes, please describe _____

History of alcohol/drug/substance use, family violence, or criminal activity? Yes / No

If yes, please describe _____

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Referral Source _____

May I thank the referral? Yes / No

I have read the above information, have asked questions as needed, and understand the issues related to the risks and benefits of psychotherapy, confidentiality, professional records, length of psychotherapy, fees, emergencies, and the obligations of clients. Based on my understanding of these issues, I agree to proceed with treatment.

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date