



# 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