FIGURE&GROUND
COUNSELING
LLC

Child-Adolescent Consent & Parent Report Form

Please provide the following information about your child:

Childs Full Name _____

Address _____

Birth Date _____ Today's Date _____

Behavioral Excesses

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? When did this start? How often does it occur? Please list all the behaviors you can think of.

1.

2.

3.

Behavioral Deficits

What does your child fail to do as often as you would like, as much as you would like, or when you would like? When did this start? How often does it occur? Please list all the behaviors you can think of.

1.

2.

3.

Behavioral Assets

What does your child do that you like? What does he /she do that other people like?

Others Concerns

Do you have any other concerns about your child or your family that you have not mentioned yet?

Priority of Treatment Goals

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change **FIRST**: and how much must they change for you to be satisfied?

Family History

The name of the child's biological parents:

Mother _____ Father _____

Who has legal guardianship of your child?

Who does your child currently live with?

Names	Ages	Relationship to child

Who are your child's significant others NOT living with your child?

Names	Ages	Relationship to child

Please describe any past counseling that either your child or any family member has had. Who? When? How long? Treatment Outcome?

Does anyone in the child's family use currently (or in the past) any type of drug _____, tobacco _____ or alcohol? _____ If yes, Please describe:

Are you concerned about the use of drugs, tobacco or alcohol in your home?

Education History

What school does your child attend? _____

Address _____

Phone _____ Teachers Name _____

Current Grade:_____

What does your child's teacher say about him/her?

Other schools attended (including Pre-school)

Has your child ever repeated a grade? If so which one(s)

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

Fighting	lack of friends	drug/alcohol	detention
Suspension	learning disabilities	poor attendance	poor grades
Gang influence	incomplete homework	behavior problems	

Medical History:

What is the name of your child's medical doctor?_____

Address _____ Phone _____

Date of your child's last medical examination _____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, Please describe them:

Has your child experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever		Convulsions/seizures
Eye/ear problems	Meningitis		Hearing problems
Allergies	Loss of consciousness		Other

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so please describe:

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

Has he/she ever purposely hurt himself or another? **Yes** **No**

If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?

Consent for Confidentiality

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Treatment Consent. Therapy is most effective when a trusting relationship exists between the therapist and a child. Privacy is especially important in securing and maintaining that trust. It is necessary for children to establish a "zone of privacy" with their therapist that allows them to feel free to discuss personal matters. Therefore, it is my policy to provide you with general information about the treatment of your child, but I will not share with you what your child has disclosed to me without your child's consent. However, if I ever believe that your child has been abused or is at serious risk of harming him/herself or another, I will inform you. This "zone of privacy" extends to information contained in treatment records as well. By signing this agreement, you are waiving your right of access to your child's treatment records. I will be happy to provide a written treatment summary upon request. Adolescence is a time when children need to develop a greater sense of independence and autonomy. If your child is an adolescent, it is possible that he/she will reveal sensitive information during therapy sessions regarding sexual contact, alcohol and/or drug use, or other potentially problematic behaviors. In order for me to effectively work with your child, it is necessary for me to maintain confidentiality about these behaviors unless they involve imminent risk of harm to self or others, such as driving while under the influence of alcohol or drugs. I will also inform you if your child does not attend sessions or if it is necessary to refer your child to another mental health professional. One risk of child therapy involves disagreement among parents and/or disagreement between parents and a therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully and try to understand your perspectives, while fully explaining mine. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. If either parent decides that therapy should end, I ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship. If conflicts arise between parents, you understand and agree that my role is strictly limited to providing

psychotherapy for the benefit of your child. This means, among other things, that you will treat anything said in session as confidential and you will not attempt to gain advantage in any legal proceeding from my involvement with your child. You agree that you will not involve me in any legal dispute, especially a dispute concerning custody or visitation arrangements. You will not ask me to testify in court, either in person or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. If a court appoints an evaluator, mediator, or guardian ad litem, I will provide information as needed, if appropriate releases are signed or a court order is provided. I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If, for any reason, I am required to participate in a legal dispute, the party responsible for my participation agrees to reimburse me at the rate of $250/hour for time spent testifying, being in attendance at hearings, or any case-related costs. Additional fees will be incurred for preparing reports, telephoning, and travel time. Thank you for your understanding and cooperation. If you have any questions about the information contained in this contract, please discuss them with me prior to signing below. Your signature indicates legally-binding agreement with the terms set forth in this contract.

Consent for Treatment

_____ (your name) am the parent or legal guardian with the authority to consent on behalf of the minor child, _____ (childs name) , I hereby give my consent for the minor to seek evaluation, counseling and psychotherapy from Jessie Moncrief, , LISW-S. Jessie has explained to me the proposed treatment plan, the general nature and extent of the risks involved in the treatment, and alternative treatment options, if any. However, treatment will not be delayed if any emergency exists. This consent will be valid until the minor reaches the age of 18, but can be revoked at any time written notification. Any questions relating to this form or the proposed treatment can be directed to Jessie Moncrief, MSSA, LISW-S at 24600 Center Ridge Rd, Suite 125. Westlake, Ohio, 44145. My contact number is (216) 221-4697

_____ (Print Name of Guardian)

_____ (Guardian Signature) _____ Date