Parent of Adolescent Confidential Information Assessment

Name:_____Date of birth:_____
Phone Number:_____Is it OK to leave a voicemail?:_____
Address:_____City, State, Zip:_____
Emergency Contact Name :_____
Phone Number:_____Relationship:_____
Consent to Contact in Case of Emergency? If yes please sign_____
Name of Person Completing Form:_____
Relationship to Child:_____
Primary Care Physician Name:_____
Primary Care Physician's Address :_____
_____
Primary Care Physician's Phone Number: _____
Reasons for bringing your child to counseling:_____
_____
_____
What caused you to bring your child in now?_____
_____
_____
Who referred you?_____
Is your child expressing suicidal thoughts or feelings?_____
Is your child expressing homicidal thoughts or feelings?_____
Does your child experience explosive anger?_____
Has your child been in counseling before(If yes, when and with whom)?_____
_____
Has your child had any experiences of abuse or neglect currently or in the past? (If yes please explain)_____
_____
_____
Has any one in your family struggled with mental health or substance abuse issues that you know about? (Examples: anxiety, depression, alcoholism, suicide)
_____
_____
_____
Has your child ever been suspended, expelled, or involved in any way with bullying?
_____
_____
Does your child have any legal issues or custody orders/agreement in place?_____
_____
Who currently lives in the primary home with the child?_____
_____
_____
Did your child reach all developmental milestones on time? If no please explain._____
_____
Does your child have any current or historical medical issues? If so please list:_____
_____
_____
_____
Is your child able to complete all activities of daily living and self care? If no, please explain._____

_____
_____
List of current medications including supplements:

_____
_____

Does your child currently use tobacco or caffeine? If yes how much and how often?._____
_____

Has your child ever consumed alcoholic beverages? If yes how much and how often?
_____

Has your child ever used drugs (Examples: marijuana, cocaine, LSD, heroin, ecstasy)? If so how much and how often?_____
_____

_____
_____

Signature of person completing form Relationship to Paitent

_____

Date

Please complete the following information if you are using insurance for services:

Insurance Carrier:_____
Plan Name:_____
Policy Number:_____
Subscriber's Name:_____Date of Birth:_____
Subscriber's Address:_____City, State, Zip:_____
Relationship to Subscriber:_____

I certify that I and/or my dependant(s) have benefits that are active through the above noted policy. I authorize Monira Philipp to share my protected health information with my insurance carrier for the purpose of obtaining coverage for my mental health care. I agree that I am financially responsible for any services or charges that are not covered by my insurance carrier. I authorize the use of my signature on claims to my insurance carrier. This authorization expires one year after termination of treatment.

_____ _____

Name Date