Minors Intake and Consent

Minor's Personal Information

Name: ______________________________ Male/Female: ___________Date: ______________________

Address: ____

Telephone: Home: ____________________ Cell: ________________ D.O.B.: ___________ Age: _______

Occupation/Position: ____

Highest Grade/Degree: _________ Referral By: ____

Person and Telephone Number to Call in Emergency: ____

Siblings (Names/Ages): ____

Parents/Stepparent(s) (Ages or Year of Death): ____

Insurance Info: ____

Presenting Problem: ____

Medical Doctor(s): _____________________ Phone(s):_____________________________________

Last Exam: ________________

Past/Present Medical Care (Specify: Major Problems, Accidents, Hospitalizations, Current Medication):

____

Past/Present Counseling/Psychotherapy/Mental Hospitals:

1. Therapist: ___________ Dates: _________ To _________Phone: ___________________________________

Address: ___________________________Initial Reason: ____

Process and Outcome: ____

2. Therapist: ____________Dates: ________ To ________ Phone: _____________________________________

Address: ___________________________Initial Reason: ____

Process and Outcome: ____

Past/Present Drug/Alcohol Use/Abuse (Any Addiction, Aa/Na, Etc.):

____

Family History Of Alcoholism, Mental Illness, Violence, Suicide:

____

Use the space on the back of this form if you need to give further information.

Minors in Therapy

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is my policy to request a written agreement from your parents or guardians indicating that they consent to give up access to such information and/or, to your records. If they agree, I will provide them only with general information about our work together subject to your approval, or, if I feel it is important for them to know in order to make sure that you and people around you are safe. If I think it is appropriate, I will involve them if I feel that there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, I will discuss the matter with you, if possible. I will do the best I can to resolve any differences that you and I may have about what I am prepared to discuss.

Consent For Treatment Of Minor(s) & Others

I give my consent that **WMY Counseling** will be conducting psychotherapy with ___________________________.

Name of Client

I was notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form, which I have read and signed.

In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept **WMY Counseling**'s judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's wellbeing.

____   ________________________

Name *(print)*   **Relationship**

____   ________________________

Signature   **Date**