

# Client Data Sheet (Child)

Please Print

Today's Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(as listed on insurance card)

Likes to be called (nickname): \_\_\_\_\_

Home address: \_\_\_\_\_  
City State Zip

Parent/Guardian phones: home \_\_\_\_\_ work \_\_\_\_\_  
cell \_\_\_\_\_

Date of Birth: mo \_\_\_\_ day \_\_\_\_ year \_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Grade Point Average: \_\_\_\_\_

### FAMILY INFORMATION

Relationship	Full Name	Place of Employment	Work Phone
Father	_____	_____	_____
Stepfather	_____	_____	_____
Mother	_____	_____	_____
Stepmother	_____	_____	_____
Guardian	_____	_____	_____

If parents are separated or divorced, who has custody? \_\_\_\_ Father \_\_\_\_ Mother  
\_\_\_\_ Joint, please explain \_\_\_\_\_

Adult household members:  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Brothers & sisters (including half or step)

Name	Sex	Age	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Religious Preference: \_\_\_\_\_

**Please complete other side**

**MEDICAL INFORMATION**

Child's Physician: \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

May we communicate with your child's physician? Yes \_\_\_\_ No \_\_\_\_

Allergies, if any: \_\_\_\_\_

Health Problems: 1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

Medications: 1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Prenatal Complications: yes \_\_\_\_ no \_\_\_\_ Birth Complications: yes \_\_\_\_ no: \_\_\_\_

Birth Weight: \_\_\_\_\_

Please write age at which child: Walked \_\_\_\_\_, Toilet trained \_\_\_\_\_,

Combined Words \_\_\_\_\_

Previous counseling: Date(s) \_\_\_\_\_; ;

Therapist(s) \_\_\_\_\_

**Insurance and Payment Information**

All professional services rendered are charged to the client or the client's parent/guardian (if child is a minor). I understand that this office files my insurance as a courtesy but the bill is my responsibility. I am responsible for all fees, including services not covered by insurance, unless expressly noted otherwise. It is customary to pay for services when rendered unless arrangements are made in advance.

Who is financially responsible for the bill:

Name	Address	City, St, Zip

Primary Insurance Company: \_\_\_\_\_

**Release of Information**

I hereby authorize Triad Counseling and Clinical Services, LLC to release any information necessary to process insurance claims concerning my diagnosis and treatment and I authorize payment of medical/psychological benefits to Triad Counseling and Clinical Services, LLC.

I understand that Triad Counseling and Clinical Services, LLC is ethically and legally required to report to legal authorities information I or my child gives them about ongoing child neglect or abuse and imminent physical danger I or my child presents to self or others.

I have read, understand and accept the above terms and conditions.

\_\_\_\_\_  
Parent or Guardian signature

\_\_\_\_\_  
Date



**CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I hereby consent to the use or disclosure of my individually identifiable health information (“protected health information” or PHI), excluding psychotherapy notes, by Triad Counseling and Clinical Services, LLC (Provider) in order to carry out treatment, payment, or health care operations (TPO). My specific authorization must be obtained for disclosure of my PHI, including summary of psychotherapy notes, for purposes other than TPO, except in special situations. I have reviewed the Notice of Privacy Practices for a more complete description of the potential disclosures of such information.

I have the right to inspect and obtain a copy of my medical/mental health records, although I understand the Provider has the right to deny such request under certain circumstances. I have the right to have a denial to inspect reviewed by a “reviewing official.” A reasonable fee may be charged for providing a copy of my records. I have the right to request amendments to the information in my medical/mental health records, although I understand the Provider has the right to deny such request. I have the right to request an accounting of disclosures of my PHI for purposes other than TOP and those for which I provided authorization. I may submit a written privacy complaint to 806 Green Valley Road, Suite 301, Greensboro, NC 27408 or to the U.S. Secretary of the Department of Health and Human Services, without any action being taken by the Provider against me without any change in my treatment.

Provider reserves the right to change the terms of its Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed, I may obtain a copy of the revised Notice by requesting a copy.

I retain the right to request that the Provider further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Provider is not required to agree to such requested restrictions; however, if the Provider does agree to by requested restriction(s), such restrictions are then binding on the Provider.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Provider in writing. The revocation shall be effective *except* to the extent that the Provider has already taken action in reliance on the Consent.

The Provider may refuse to treat me if I (or authorized representative) do not sign the Consent portion of this form (except to the extent that the Provider is required by law to treat individuals). If I (or authorized representative) sign the Consent portion and then revoke Consent, the Provider has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Provider is required by law to treat individuals).

I \_\_\_\_\_ **CONSENT TO THE RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.**

I \_\_\_\_\_ **DO NOT CONSENT TO THE RELEASE FOR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.**

I \_\_\_\_\_ **HAVE HAD AN OPPORTUNITY TO REVIEW THE PROVIDER’S NOTICE OF PRIVACY PRACTICES.**

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient (or authorized representative)

\_\_\_\_\_  
Please Print Name

Representative’s Authority to act on behalf of the Patient: \_\_\_\_\_

For Office Use only: Acknowledgement of Privacy Practices was not obtained because:

CONSENT FOR RELEASE OF MENTAL HEALTH INFORMATION

This form is used to be able to discuss or release information to your (or your child's) primary care doctor only, in order to coordinate treatment.

If you wish for information to be released to the primary care doctor only, please fill in the name of that doctor, check the authorization line and sign and date the form.

If you DO NOT wish for information to be released to the primary care doctor, check by the decline line and sign and date the form.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_mo \_\_\_day \_\_\_year

Mental Health Provider Name: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Primary Care Physician Address: \_\_\_\_\_  
Street City, State

Primary Care Physician Phone: \_\_\_\_\_

\_\_\_\_\_ I authorize the release of relevant treatment information to the provider named above. I understand that these records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. My consent may be revoked at any time, and expires one year from the date signed.

\_\_\_\_\_ I decline the release of treatment information to my Primary Care Physician.

\_\_\_\_\_  
Signature of Patient or Legal Guardian Date

\_\_\_\_\_  
Relationship to Patient

**Triad Counseling and Clinical Services**

806 Green Valley Rd Suite 301  
Greensboro, NC 27408  
336-272-8090 Office 336-272-0094 Fax

232 Woodrow Ave  
High Point, NC 27262  
336-882-2812 Office 336-882-8632 Fax

**Youth Wellness Assessment**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Relationship to child: \_\_\_ Mother \_\_\_ Father \_\_\_ Stepparent \_\_\_ Self \_\_\_ Guardian/other

Completing this brief questionnaire will help us provide services that meet your child's needs.

<b>Which best describes your child:</b>	<b><u>Never</u></b>	<b><u>Sometimes</u></b>	<b><u>Often</u></b>
1. Destroys property	_____	_____	_____
2. Is unhappy or sad	_____	_____	_____
3. Behavior causes school problems	_____	_____	_____
4. Has temper outburst	_____	_____	_____
5. Worrying prevents him/her from doing things	_____	_____	_____
6. Feels worthless or inferior	_____	_____	_____
7. Has trouble sleeping	_____	_____	_____
8. Changes moods quickly	_____	_____	_____
9. Uses alcohol	_____	_____	_____
10. Uses illegal drugs	_____	_____	_____
11. Is restless, trouble staying seated	_____	_____	_____
12. Engages in repetitious behavior	_____	_____	_____
13. Worries about almost everything	_____	_____	_____
14. Needs constant attention	_____	_____	_____
15. Bullies others	_____	_____	_____
16. Is being bullied by others	_____	_____	_____
17. Weight loss/or gain as a result of eating habits	_____	_____	_____
18. Concerns with peer/social relationships	_____	_____	_____

<b>How much have your child's problems caused:</b>	<b><u>Not at all</u></b>	<b><u>A little</u></b>	<b><u>Somewhat</u></b>	<b><u>A lot</u></b>
1. Interruption of personal time	_____	_____	_____	_____
2. Disruption of family routines	_____	_____	_____	_____
3. Less attention paid to any family member	_____	_____	_____	_____
4. Disruption or upset of relationships within the family	_____	_____	_____	_____
5. Disruption or upset of your families social activities	_____	_____	_____	_____
6. Any family member to suffer mental or physical illness	_____	_____	_____	_____
7. How many days in the past week was your child's usual routine interrupted by their problems _____ Days	_____	_____	_____	_____
8. In general would you say your child's health is: ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor	_____	_____	_____	_____
9. In the past 6 months, how many times did your child visit a medical doctor ___ none ___ 1 ___ 2-3 ___ 4-5 ___ 6+	_____	_____	_____	_____
10. In the past month, how many days were you unable to work because of your child's problems _____ Days	_____	_____	_____	_____
11. In the past month, how many days have you had to cut back on how much you got done because of your child's problems _____ Days	_____	_____	_____	_____