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CONSENT FOR TREATMENT OF A MINOR CHILD

(The following statements provide your legal consent to and financial responsibility for counseling services to a minor child. These statements are important to protect the child, the parent/guardian/conservator, and the therapist. Please carefully review this information and sign where indicated. You are requested to discuss any question you may have with the therapist.)

STATEMENT OF RESPONSIBILITY AND GRANT OF PERMISSION FOR THERAPY

I am the : Natural Parent: [] Legal Guardian: [] Managing Conservator of []

(Name of minor child)

I am legally responsible for the child named above and grant permission to Gary R. Mauldin Ph.D., LMFT to conduct therapy with this child.

Signature: _____ Date: _____

CONFIDENTIALITY NOTICE

Gary R. Mauldin Ph.D., LMFT, is committed to the confidentiality and privileged communication with all clients. There are, however, several exceptions. According to State law, any evidence of child abuse must be reported to the authorities. If any individual intends to take harmful, dangerous, or criminal action against another individual, or against himself/herself, it may be the therapist's duty to report such action or intent.

Signature: _____ Date: _____

INTAKE FORM

Therapist: _____ *Today 's Date* _____ *File #* _____

PERSONAL IDENTIFICATION

First Name: _____ ML: _____ Phone #: (h) _____ (w) _____

Last Name: _____ Birth Date: _____

Address: _____ Gender: _____ Male _____ Female _____

City, St, Zip: _____ Social Security Number: _____

RESPONSIBLE PARTY (if other than above)

First Name: _____ Phone #: (h) _____ (w) _____

Last Name: _____

Address: _____

City, St, Zip: _____

CHILD INTAKE FORM

Child's Given Name _____ Date of Birth _____ Client # _____

DEVELOPMENTAL HISTORY:

Was the pregnancy planned? Yes [] No [] Or Is child adopted? Yes [] No [] Age at adoption _____

Describe any complications experienced during pregnancy _____

Describe any complications during birth & delivery _____

Any problems feeding? Yes [] No [] Age _____ Duration _____

Any problems eating? Yes [] No [] Describe _____

Any problems sleeping? Yes [] No [] Describe _____

Have there been any physical or emotional separations (i.e. death, hospitalizations) between child and care taking adult during the first 26 months of life?

Yes [] No [] If yes, explain: _____

Is there any history that could be considered abusive?

Yes [] No [] If yes, was it physical? _____ emotional _____ sexual _____

Age he/she:

Held head up _____ Turned over _____ Sat _____ Pulled up _____

Smiled at parents _____ Crawled _____ Walked with help _____ Was weaned _____

Used sentences _____ Fed self _____ Helped dress self _____ Dressed alone _____

Dry during day _____ Dry during night _____

Is he/she:

Impulsive _____ Timid or shy _____ Right/left handed _____

Stubborn _____ Well coordinated _____ Clumsy _____ Affectionate _____

Any previous testing or therapy?

Yes [] No []

Dates _____ Place _____

Findings _____

List any special problems that might have caused stress for your child _____

How did you choose this time to seek counseling? _____

SCHOOL INFORMATION:

(please fill in where appropriate)

Teacher: _____ School: _____

Grade: _____ Year Enrolled: _____ School Phone: _____

Has child been: Tutored _____ In special class: _____ Expelled: _____ Suspended: _____

Repeated a grade: _____ Cut classes: _____

The school has said my child: Is hyperactive _____ Is bored _____ Procrastinates _____

Gets along well with adults. _____

Gets along well with students. _____

Has few friends. _____

IQ is above/below average _____

FAMILY INFORMATION:

Who wanted help?

Five adjectives describing mother:

Five adjectives describing father:

Five adjectives describing parental relationship:

PERSONAL INFORMATION:

Pediatrician: _____ Pediatrician's phone: _____

Address: _____ City, State Zip: _____

List any present medical problems and current medications: _____

Has child had counseling and/or psychiatric care? Yes No

If yes, when: _____

Doctor or counselor: _____ Phone: _____

Address: _____ City, State Zip: _____

Please answer all questions by a check mark indicating the degree of the problem.

		<i>Not at All</i>	<i>Just a little</i>	<i>Pretty much</i>	<i>Very much</i>
1.	Picks at things (nails, fingers, hair, clothing)	[]	[]	[]	[]
2.	Sassy to grownups	[]	[]	[]	[]
3.	Excitable, impulsive	[]	[]	[]	[]
4.	Problems with making or keeping friends	[]	[]	[]	[]
5.	Wants to run things	[]	[]	[]	[]
6.	Sucks or chews (thumbs, clothing, blankets)	[]	[]	[]	[]
7.	Cries easily or often	[]	[]	[]	[]
8.	Carries a chip on his shoulder	[]	[]	[]	[]
9.	Daydreams	[]	[]	[]	[]
10.	Difficulty in learning	[]	[]	[]	[]
11.	Restless in the "squirmy" sense	[]	[]	[]	[]
12.	Fearful (of new situations, new people or places)	[]	[]	[]	[]
13.	Restless, always up and on the go	[]	[]	[]	[]
14.	Distinctive	[]	[]	[]	[]
15.	Tells lies or stories that aren't true	[]	[]	[]	[]
16.	Shy	[]	[]	[]	[]
17.	Gets into more trouble than others same age	[]	[]	[]	[]
18.	Speaks differently than others same age (baby talk, stuttering, hard to understand)	[]	[]	[]	[]
19.	Denies mistakes or blames others	[]	[]	[]	[]
20.	Quarrelsome	[]	[]	[]	[]
21.	Pouts and sulks	[]	[]	[]	[]
22.	Steals	[]	[]	[]	[]
23.	Disobedient or obeys resentfully	[]	[]	[]	[]
24.	Worries more than others (about being alone, illness, death)	[]	[]	[]	[]
25.	Fails to finish things	[]	[]	[]	[]
26.	Feelings easily hurt	[]	[]	[]	[]
27.	Bullies others	[]	[]	[]	[]
28.	Unable to stop a repetitive activity	[]	[]	[]	[]
29.	Cruel	[]	[]	[]	[]
30.	Childish or immature (wants help he shouldn't need, clings, needs constant reassurance)	[]	[]	[]	[]
31.	Distractibility or attention span a problem	[]	[]	[]	[]
32.	Headaches	[]	[]	[]	[]
33.	Mood changes quickly and drastically	[]	[]	[]	[]
34.	Doesn't like or doesn't follow rules or restrictions	[]	[]	[]	[]
35.	Fights constantly	[]	[]	[]	[]
36.	Doesn't get along well with brothers or sisters	[]	[]	[]	[]
37.	Easily frustrated in efforts	[]	[]	[]	[]
38.	Disturbs other children	[]	[]	[]	[]
39.	Basically an unhappy child	[]	[]	[]	[]
40.	Problems with eating (poor appetite)	[]	[]	[]	[]
41.	Stomach aches and pains	[]	[]	[]	[]
42.	Problems sleeping (can't fall asleep, up during night)~]	[]	[]	[]	[]
43.	Other aches and pains	[]	[]	[]	[]
44.	Vomiting or nausea	[]	[]	[]	[]
45.	Feels cheated in family circle	[]	[]	[]	[]
46.	Boasts and brags	[]	[]	[]	[]
47.	Lets self be pushed around	[]	[]	[]	[]
48.	Bowel problems (frequently loose, irregular habits)	[]	[]	[]	[]