Child's First Name:	Child's Last Name:

Choices in Counseling

Child/Adolescent Admissions Packet

Directions:

This packet is intended for children/adolescents that are 18 years old or younger that are still in the care of a parent or guardian. If you are over 18 years old or older and not under the direct care/supervision of a parent or guardian, please complete the Adult Admissions Packet.

Please fill-out the entire packet as accurately and completely as possible. This information will be used to help provide you with the best possible service while working with Choices in Counseling. The more detailed the information that you can provide in your initial admissions packet the better we can identify your current needs and begin to structure your treatment to address those needs. If a question does not apply to your current situation, please place an "NA" in the space provided for the answer to that question instead of leaving it blank.

CHILD/ADOLSESCENT REGISTRATION

Date Initial Appointment Scheduled:			(PLEASE PRINT – PLACE "**NA**" IN FIELDS NOT APPLICABLE)
CHILD'S CONTACT INFORMATION			
Last Name:	First:		Middle:
Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security#:
Legal Father's Name:			Living with the child full-time? ❑ Yes ❑ No
Legal Mother's Name:			Living with the child full-time? ❑ Yes ❑ No
Parents Relationship: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Separated ❑Widow			How Long? _____ Yrs.
Street address:			P.O. Box:
City:	State:	Zip:	County:
Primary Phone: ( )	Secondary Phone: ( )		Other Phone: ( )
Email Address:			
Other Contact Method:			
Who is the primary guardian for the above minor?			
For reminder phone calls and scheduling purposes, what is the best way(s) to contact you? (Check all)			❑ Primary Phone ❑ Secondary Phone ❑ Email ❑ Text Message ❑ Other:
When is your preferred time to schedule appointments?			Day (Circle all that apply): Mon. Tues. Wed. Thu. Fri. Sat.
Notes:			Time (Circle all that apply): Morning Afternoon Evening ANY
REFERRAL INFORMATION			
How did you hear about us? ❑ Dr. _____ ❑ Insurance Company ❑ Hospital ❑ Family ❑ Friend			
(Please Check All That Apply): ❑ Yellow Pages ❑ Internet Listing ❑ Web Page ❑ Other: _____			
Name of Individual that Referred You:			Phone: ( )
Do you have other family member(s) that are/have been seen here: ❑ Yes ❑ No *(If yes, please list):*			

CHILD'S PRIMARY HEALTH INFORMATION			
Name of Primary Care Physician:			Phone: ( )
Primary Physician Address:			Fax: ( )
City:	State:	Zip Code:	Date Last Seen: / /
Does your child have any medical conditions? ❑ Yes ❑ No ***If yes, please list:***			
Is your child taking any medications? ❑ Yes ❑ No ***If yes, please list (Include Name, Dosage, Frequency):***			

CHILD'S EMPLOYER INFORMATION			
Occupation:	Employer:	Phone: ( )	
Employer Address:		Years Employed:	
Employer City:		State:	Zip:

CHILD'S SCHOOL INFORMATION		
School Name:		Grade:
School Address:		
School City:	State:	Zip:
School Phone: ( )	School Fax: ( )	
Primary Teacher Name:	Other Contact:	
Primary Teacher Email:	Primary Teacher Phone: ( )	
School Comments:		

CHILD'S PRIMARY INSURANCE/EAP INFORMATION		
Does your child have **primary insurance/EAP** that you would like to have Choices seek reimbursement from? ❑ Yes ❑ No		
Subscriber's Name:	Relationship to Client:	
Subscriber's Address:		
City:	State:	Zip:
Subscriber's Phone: ( )	Subscriber's DOB: / /	
Subscriber's Employer's Name:	Subscribers Social Security#:	
Employer address:	Employer Phone: ( )	
Name of the Insurance/EAP Company:		
Insurance/EAP Customer Care Phone Number(s):		
Group Number:	Policy Number:	Co-pay: $

CHILD'S SECONDARY INSURANCE INFORMATION		
Does your child have **secondary insurance** that you would like to have Choices seek reimbursement from? ❑ Yes ❑ No		
Subscriber's Name:	Relationship to Client:	
Subscriber's Address:		
City:	State:	Zip:
Subscriber's Phone: ( )	Subscriber's DOB: / /	
Subscriber's Employer's Name:	Subscribers Social Security#:	
Employer Address:	Employer Phone: ( )	
Name of Insurance Company:		
Insurance Customer Care Phone Number(s):		
Group Number:	Policy Number:	Co-Pay: $

EMERGENCY CONTACT(S)		
Please list a family member or relative along with their phone number(s) that can be contacted in case of an emergency.		
Name	Relationship	Phone Number

CHILD'S HOUSEHOLD FAMILY INFORMATION			
Please list all members of the family, extended family, and other individuals ***currently living in the home***			
Name	Age	Relationship	Occupation **or** School & Grade
Comments:			

CHILD'S EXTENDED FAMILY SUPPORTS NOT LIVING IN THE HOME			
Please list all members of the family, extended family and others ***not living in the home*** *that should be considered part of treatment*			
Name	Age	Relationship	Occupation **or** School & Grade
Comments:			

CHILD'S DEVELOPMENT & CURRENT FUNCTIONING ASSESSMENT

*Please check **all** of the items listed below that apply which may be considered as part of your child's concerns for treatment.*
Please add additional comments for checked items.

BIRTH/EARLY DEV

- ❑ There were complications with the pregnancy/birth.
- ❑ Could **not** walk independently at18 months of age.
- ❑ Could **not** speak in sentences by age 3.
- ❑ Could **not** tie shoestrings independently by age 6.
- ❑ Did **not** develop as fast as their brothers/sisters.
- ❑ Struggles with pronouncing words correctly.

Please add comments for checked items →

Additional Comments on **Birth and Early Development**:

EDUCATION

- ❑ Has attendance problems at school.
- ❑ Often hits, threatens or fights with other at school.
- ❑ Often disrespectful and/or talks back to teachers.
- ❑ Has difficulty following school rules.
- ❑ Has difficulty paying attention in the classroom.
- ❑ Struggles with making good grades at school.
- ❑ Receives tutoring and/or has an IEP at school.
- ❑ Has been held back a grade(s) in school.

Please add comments for checked items →

Additional Comments on **Education**:

HOME

- ❑ Has left the home without permission.
- ❑ Often has temper tantrums or outbursts.
- ❑ Often disrespectful or talks back to parents/adults.
- ❑ Has difficulty following rules at home.
- ❑ Often demands frequent attention from others.
- ❑ Struggles with making good choices.

Please add comments for checked items →

Additional Comments on **Home**:

COMMUNITY

- ❑ Has had contact with the police.
- ❑ Has been charged with a crime as a juvenile.
- ❑ Has shoplifted from a store.
- ❑ Has stolen items from friends/neighbors.
- ❑ Has been caught vandalizing property.
- ❑ Has damaged others property intentionally.
- ❑ Has been involved in other illegal activities.
- ❑ Other family members have had legal issues.

Please add comments for checked items →

Additional Comments on **Community**:

FAMILY

- ❑ His/her family has experienced stress.
- ❑ Family has had a recent loss or death.
- ❑ Family argues/fights with one another.
- ❑ Parents have struggled with marital difficulty.
- ❑ Parents have recently been separated.
- ❑ Parents have been remarried.
- ❑ Parents struggle with effective discipline.
- ❑ Family struggles with financial concerns.
- ❑ Family has concerns with safety of the home.
- ❑ Reports of abuse/neglect have been made.

Please add comments for checked items →

Additional Comments on **Family**:

SOCIAL BEHAVIOR

- ❑ Does not have friends his/her own age.
- ❑ Withdraws from others in the community.
- ❑ Does not have positive relationships with peers.
- ❑ Does not have positive relationships with adults.
- ❑ Does not have interests that he/she enjoys.
- ❑ Engages in inappropriate interactions with peers.

Please add comments for checked items →

Additional Comments on **Social Behavior**:

EMOTIONS/HARM

- ❑ Has experienced a trauma.
- ❑ Has had a change in mood/emotions recently.
- ❑ Frequently worries.
- ❑ Frequently angry.
- ❑ Has frequent nightmares.
- ❑ Is often sad, tearful.
- ❑ Struggles with low self-esteem.

Please add comments for checked items →

Additional Comments on **Emotions**:

MENTAL HEALTH

- ❑ Has had a history of counseling.
- ❑ Has been hospitalized for mental health.
- ❑ Has had a history of med management.
- ❑ Is currently taking medications.
- ❑ There is a family history of mental health.

- ❑ Has attempted to harm himself/herself
- ❑ Has talked about harming himself/herself
- ❑ Has harmed someone else
- ❑ Has talked about harming someone else

Please add comments for checked items →

Additional Comments on **Mental Health**:

PHYSICAL HEALTH

- ❑ Has struggled with a chronic health condition.
- ❑ Has been hospitalized for physical health.
- ❑ Has had major surgery.
- ❑ Has a history of significant injuries.
- ❑ Struggles with ongoing physical pain.
- ❑ Has an allergy.
- ❑ Is on a special diet.

- ❑ Has abused drugs or alcohol*

Please add comments for checked items →

Additional Comments on **Physical Health**:

CHILD'S STRENGTHS AND GOALS FOR TREATMENT

CHILD STRENGTHS	What strengths does your child have?

1. _____
2. _____
3. _____
4. _____

CHILD'S GOALS FOR TREATMENT	What goals do you have for your child's individual/family counseling?

1. _____
2. _____
3. _____
4. _____

Additional comments/questions for therapist's consideration:

Note:

- Please be sure that you have filled-out the entire Child Registration Packet as accurately and completely as possible. Make sure that you add comments on items in the Development and Current Functioning Assessment.
- If you are in need of additional space to more fully explain your child or family's history please feel free to attach additional pages with these comments.
- If you have any difficulty or questions with any part of the registration packet, please feel free to note these questions for further review at the time of your first appointment or contact our office at (317) 346-6252 to speak with someone directly.
- Please bring your completed paperwork to your first appointment along with your primary insurance information (and secondary if applicable) and insurance card(s) as we will make a copy of this information for our records.

By signing below I agree that all of the information contained in this registration packet (pages 1-9) is accurate and has been completed to the best of my ability. My signature below indicates that I fully understand and agree to comply with all terms and conditions outlined in the Client Rights and Responsibilities document available through the Choices in Counseling web site at: www.ChoicesInCounseling.com and/or by request at the Choices in Counseling office.

I authorize my insurance benefits to be paid directly to the appropriate clinician through Choices in Counseling. ***I fully understand that I am financially responsible for any balance that remains on my account regardless of circumstances.*** *I also herby authorize the appropriate clinician through Choices in Counseling and any insurance company(s) listed above to release any information required to process my claims. My signature also confirms that I have read my Client Rights and Responsibilities and fully understand my rights and responsibilities as a client of Choices In Counseling.*

The undersigned certifies that he/she has read and understands the foregoing, is the client, or the client's parent or legal guardian, and agrees to and accepts the terms above.

Client/Guardian Signature	Date	Therapist Signature	Date

Printed Name

Relationship to Child