Serene Pathways Counseling, LLC
516 S. Creyts Rd., Suite F
517.323.1767
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All submitted information is confidential. If an item does not apply to you write "NA".

Child and Adolescent History

Name: _____ Today's Date: _____

Address: _____

_____

Date of Birth: _____ Place of Birth: _____

School: _____Grade completed:_____

Parent(s)/Guardian(s):_____

_____

Please describe the reason for the appointment: _____

_____

Family Information

Parent (s)/Guardian(s) (including step-parents and foster parents): _____

_____

_____

Contact information of non-custodial parent (if available): _____

Please list who can give permission to seek treatment for this child: _____

_____

Marital status of responsible parties: _____ married _____ never married _____separated _____divorced _____other

Please describe current living situation: _____

_____

_____

Siblings names and ages: _____

_____

_____

Extracurricular Activities

Does the child participate in extracurricular activities? _____

If yes, please list:_____

_____

If client is an adolescent, is he/she currently employed? Yes____

Employer: _____ Position: _____ Length: _____

How would you describe your current work situation? _____

_____

_____

Hobbies/Interests

_____

_____

Describe your child in 3 to 5 words: _____

_____

Optional Information

Race and Ethnicity: _____

Religious Affiliation: _____

Other information that you feel might be helpful when providing

services:_____

_____

Responsible Party/Insurance information

Responsible party if minor, etc: _____

Phone number:_____

Primary Insurance information (please present card)

Insurance:_____Employer:_____

Subscriber or enrollee ID number: _____

Policy holder's name: _____DOB: _____

Secondary Insurance information (please present card)

Insurance: _____Employer: _____

Subscriber or enrollee ID number: _____

Policy holder's name: _____DOB: _____

Medical Information

Primary Care Physician: _____ Date of Last Physical: _____

List any current medication, dosage, and reason (including vitamins/herbs/over the counter medication) for medication: _____

_____

_____

Physical concerns _____Headaches _____Sleep _____ Stomach _____Other

Please explain: _____

_____

Were there any problems with the pregnancy or delivery? _____Yes _____No

Explain:_____

_____

Were there any delays in development? _____Yes _____No

Explain:_____

_____

Emotional Concerns (Please check any that apply):

_____ Depression _____Anxiety _____ Anger _____Other

_____Nightmares _____Family Problems _____ Stress

_____Acting out sexually _____ Suicidal thoughts or actions _____ Fear

Please explain: _____

_____

_____

_____

Is the child currently or has he/she been in the past under the care of another mental health professional (i.e. psychiatrist, psychologist, counselor, etc.)? _____Yes _____No If yes, please explain

_____

_____

Are any family members currently under the care of a mental health professional (i.e. psychiatrist, psychologist, counselor, etc.)? If yes, please explain_____

_____

Does the child or any family members have any history of depression or other similar problems (i.e. anxiety, manic depression, schizophrenia)? Yes _____No_____ If yes, please explain:

_____

_____

Does the child or any family members have any history of drug/alcohol abuse? _____ Yes ____ No

Explain_____

_____

_____

Is there a history of or is there currently any type of abuse or neglect towards the child? ____Yes ____ No

Explain_____

_____

If yes, has this information been reported to the proper authorities? ____Yes ___No. If yes, is there an open case or pending investigation?

Explain_____

_____

Has the child had any academic or behavioral problems in school? _____Yes _____No

If yes, please check all that apply:

_____poor attention span/excessive fidgeting

_____not able to stay on task/turn in assignments

_____declining/failing grades

_____speech problems

_____multiple detentions/visits to principal's office

_____uncharacteristic behavior

_____arguing/fighting/hitting

_____refuses or unable to follow directions

_____other _____

Have you been told that your child has a learning disability? _____

If yes, please explain:

_____

_____

Is there anything that may interfere with counseling? _____

_____

Communication by Email/Texting

_____I disagree with sending or receiving communication through either of these forms of communication.

_____I agree with sending or receiving communication through the following:

_____Email- address is: _____

_____Text- phone number is: _____

_____

Signature of Minor Child

_____

Signature of Responsible Adult

Notice of Privacy Practices Receipt and Acknowledgment

I, the undersigned, hereby acknowledge receipt of the Notice of Privacy Practices given to me by Serene Pathways Counseling, LLC.

Cancellation Policy

I, the undersigned, understand that the therapists of Serene Pathways Counseling respect my time and ask that I respect theirs as well. I understand that if I cannot give 24 hours' notice of a cancellation that I may be charged a $35 fee which is payable prior to resuming counseling services. This fee is not billable to my insurance company (third party payer)

Financial Responsibility

I, the undersigned, hereby authorize release of information necessary for SPC to file a claim with my insurance company (third party payer) and assign benefits otherwise payable to me to the provider or group indicated on the claim. I understand that I am financially responsible for any balance not covered by the third party payer, i.e. co-payments, co-insurance, deductibles or non-covered services.

Consent to Treat

I verify that the information given is correct and that I am the parent and/or legal guardian of the minor child _____and have legal authority to seek services for him/her.

_____Date_____

Signature Responsible Party of Minor Child

_____Date_____

Signature of Staff Member