



**Child Intake Form**

Name of Child: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Child's School/Daycare: \_\_\_\_\_ School Phone #: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Please list any medications your child is currently taking, including psychotropic medications:

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Please describe any medical conditions I should be aware of (allergies, injuries, illnesses, etc):

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Please describe your current household composition (names, ages, and relationship of those living with your child):

Relationship	Name	Age	good	fair	poor
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

The reason I am seeking therapy for my child is:

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What are you most concerned about?

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What changes would you like to see in your child as a result of therapy?

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### Child History

Name of Child: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Is your child adopted?----- yes no

Has your child ever been or is he/she currently in foster care?----- yes no

Explain: \_\_\_\_\_

Has your child received any previous counseling or treatment?----- yes no

Explain: \_\_\_\_\_

Were there any problems or complications during pregnancy or birth?----- yes no

Explain: \_\_\_\_\_

Has your child experienced any form of abuse (physical, emotional, sexual)? yes no

Explain: \_\_\_\_\_

Has your child experienced any significant trauma or losses?----- yes no

Explain: \_\_\_\_\_

Has your child experienced any divorces or separations?----- yes no

Explain: \_\_\_\_\_

Does your child have difficulty at school or daycare?----- yes no

Explain: \_\_\_\_\_

Does your child generally get along with other children his/her own age?---- yes no

Does your child generally get along with adults?----- yes no

Does your child have unusual eating patterns?----- yes no

Explain: \_\_\_\_\_

Does your child have unusual sleeping patterns?----- yes no

Explain: \_\_\_\_\_



**Child's Family History**

Current custody status:

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Visitation arrangements:

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What are your main approaches to discipline?

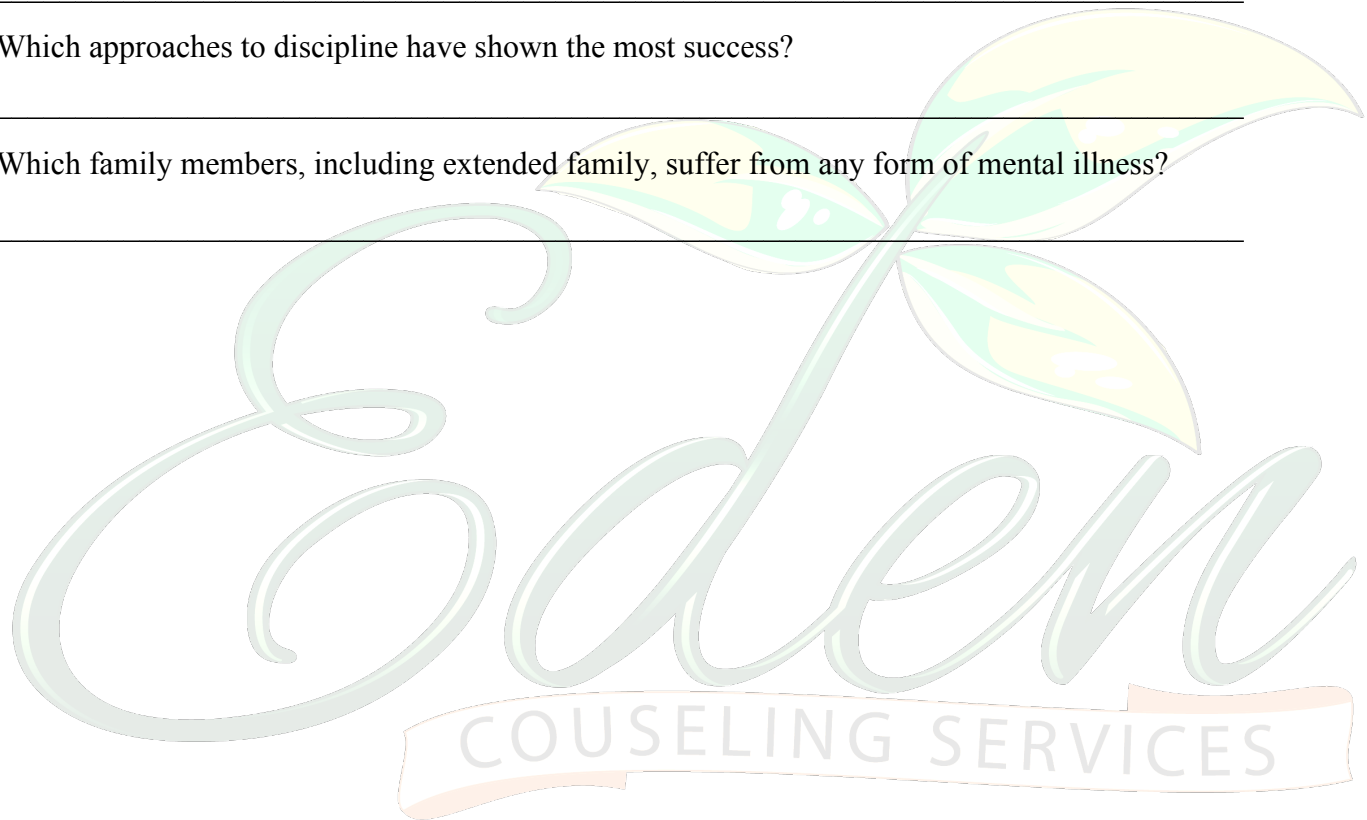
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Which approaches to discipline have shown the most success?

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Which family members, including extended family, suffer from any form of mental illness?

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**Consent to Treat a Minor**

Name of minor client: \_\_\_\_\_ Date of birth: \_\_\_\_\_

This is to certify that you give permission to Ashley Ojo, MA, LPC, NCC for the treatment of your child, \_\_\_\_\_ . This treatment may include individual or group psychotherapy, counseling, and testing. This treatment may also include referrals to other appropriate State, County or other professional agencies. One of my stipulations in treating your child is that you as a parent/guardian also be involved in the therapeutic process. By signing this consent form, you are also agreeing to attend occasional sessions at which I request your presence.

In addition, you as a parent/guardian agree to the following stipulations:

- Although your child is a minor, he/she has the right to confidentiality. This confidentiality is crucial for a child to feel safe and secure in the counseling environment and a necessary ingredient for treatment success. You agree to honor this right to confidentiality. Children age 14 and older have the right to full client privilege. Parents of children younger than 14 have the right to information regarding the minor’s treatment so long as it is in the best interest of the child.
- In cases of divorce or parental conflict, you agree to not request that I participate in any court proceedings, to include but not limited to, testifying, providing records, or writing letters of summary or recommendation.

\*\*I have a legal right to  sole /  shared medical decision making regarding the following children:

I understand that I may revoke this authorization by submitting my request in writing to Ashley Ojo, MA, LPC, NCC.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Ashley Ojo, MA, LPC, NCC



\_\_\_\_\_  
Date

**\*\*In cases of joint custody or shared allocation of parental responsibility for medical decisions, a copy of the divorce decree and custody order along with signatures indicating consent from both parents are required in order to treat a minor, except in emergencies.**



**Financial Agreement Form**

I agree to the following financial payment and procedures.

1. To pay \$150 for the initial assessment and \$100 per 50 minute session thereafter.
2. To pay a prorated fee for consultations over the phone that involves therapeutic issues other than obtaining and canceling appointments.
3. To pay an hourly rate of \$100 for time spent preparing and writing any formal or legal documentation including but not limited to court letters, disability determinations, assessments, treatment summaries, and so forth.
4. Payment is expected at the beginning or end of each session, unless prior arrangements have been made.
5. *Appointments not cancelled 24 hours in advance* will be charged to my account and must be paid at the next session.
6. A \$20 service charge will be added to all returned checks and must be paid at the next session.
7. Payments of fees are the full responsibility of the client. Insurance is billed as a courtesy only and does not guarantee that all fees will be covered by insurance
8. Explanation of any alternate payment plan:

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*I would like Eden Counseling Services to bill my insurance.*

*Initials*

**Insurance Information**

Name of Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

Phone Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Policy ID or Social Security Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

I understand the above payment procedures and I agree to this plan of payment.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_