Creative Healing and Wellness, Inc.
21 East 2nd Street Riverhead, NY 11901
631-488-1790
creativehealingandwellnessny@gmail.com

Today's Date:___________________

IDENTIFYING INFORMATION

Child's Name: ____ Sex: (M)_____ (F) _____
DOB: _________________________Grade in school:_________ Age: __________
Mother's Name: ____ DOB: __________________
Natural parent: ______ Relative: _____ Step Parent: ______ Adoptive Parent: ______
Father's Name: ____ DOB: __________________
Natural parent: ______ Relative: _____Step Parent: ______ Adoptive Parent: ______
Address (Number and Street): ____
City: ____________________________ State: _____________________ Zip: ____________________________
Home Telephone: ______________________ Mom Work: __________________ Dad Work: ___________________
Cell Phone: _______________________ E-mail:____
Emergency Contact/Relation: ______________________________ Emergency Phone #: _____________________
For what are you seeking help with today? ____
____
____
What would you like to accomplish out of you or your child's time in therapy? ____________________________
____
____
Name of person completing information/relationship to child: ____

Presenting Problems (check all that apply):

__ Temper outbursts
__ Withdrawn
__ Daydreaming
__ Fearful
__ Clumsy
__ Overactive
__ Short attention span
__ Distractible
__ Peer conflict
__ Phobic
__ Impulsive
__ Stubborn
__ Disobedient
__ Infantile
__ Mean to others
__ Destructive
__ Bed wetting
__ Self-mutilating
__ Head banging
__ Rocking
__ Stealing
__ Lying
__ Shy
__ Strange behavior
__ Sleeping problems
__ Drug/Alcohol use
__ Sickly
__ Feeding/Eating problems
__ School trouble
__ Bowel/bladder control
__ Other (explain):
____
____
____

MEDICAL HISTORY

Has the child ever been hospitalized for illness, physical ailments, emotional problems etc? Y___ N___
If yes, please explain where, when, and what for?
____
____
____
____

Has the child ever taken, or is he/she currently taking any medications? Y____ N ____
If yes, please list medication name and frequency of dosage _________________________________
____
____

Does the child have any allergies that you are aware of (i.e. latex, peanut, soy, citrus etc.)?__________
____

Describe your child's eating and drinking habits and what he/she eats & drinks:
____
____

Describe your child's bedtime routine including bedtime and sleeping arrangements: _______________
____
____

Name and address of primary care Physician ____
____
____

LIVING ARRANGEMENTS

Number of moves in child's life ________ Ever placed, boarded, or lived away from family? Y ___ N ___
Explain:
____

Present home: Renting ______ Buying ______ House_____ Apartment ______
List all members of your household presently and indicate their relation to the patient: _____________
____
____
____
____.

Are you interested in counseling services for yourself or any of your family members? Y_____ N _____

DEVELOPMENTAL HISTORY

Did mother have any illness or complications before delivery? Y____ N____ If yes, please explain
____
____

Did mother abuse alcohol or drugs during pregnancy? Y____ N____
Length of pregnancy: _________________ Full Term? Y____ N ____ Birth Weight ____lbs _____oz
Complications at birth? (Explain)____
____
____

As far as you know, did your child meet developmental milestones at an appropriate age (i.e. rolling, sitting up, babbling, and eating)? Y____ N ____

____
____

EDUCATIONAL HISTORY
Name of School/Daycare
____
Types of classes: Regular ___ Inclusion ___ESE ___EDB (Emotionally Disturbed Behavior) ___Other (explain): ____
Does the child receive special services at school? Y ____ N ____ If yes, which services and what is the frequency/duration of each?
____ Occupational Therapy ____ / week for ____ minute sessions
____ Physical Therapy _____ / week for ____ minute sessions
____ Speech Therapy _____ / week for ____ minute sessions
____ Counseling _____/ week for ____ minute sessions

SOCIAL HISTORY
Does the child attend extracurricular activities?
____
____
In school, how many friends does the child have? ____
Other information you think would help me to better understand your child and your family:
____
____

RELEASE OF INFORMATION

You may consent for personal information contained within your clinical record held by Creative Healing and Wellness, LLC to be disclosed to the persons and/or agencies identified below for the following reasons:

- Planning and monitoring appropriate treatment.
- Case review and consultation with your physician and/or health care providers.
- Support and/or Involvement of family member(s) or significant other in treatment.

Your signature indicates that you authorize Dana Bordsen to release/receive information to the parties named below. You may revoke this consent at any time by providing written notice. Please refer to the HIPAA guidelines for additional privacy information.

Name of primary physician: ____
Address:____
Phone: ______________________________________

Any other parties (i.e. attorney, employer, community agency) that you authorize Dana Bordsen to give/receive information regarding your treatment:

____
____
____

Family member(s)/significant other who may participate in you or your child's therapy. Please indicate relationship to client.

____
____

Print Client's Name: ____________________________________ DOB: _____________________

Client's Signature or Parent/Guardian Signature(if under 18): _______________________________
Date: _______________________________

Witnessed By: ____
Date: ________________________

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

____

Duty to Warn and Protect When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
Abuse of Children and Vulnerable Adults If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
Prenatal Exposure to Controlled Substances Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
Minors/Guardianship Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. *Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.
I agree to the above limits of confidentiality and understand their meanings and ramifications.

____

Client Signature (Client's Parent/Guardian if under 18)

____

Today's Date

CANCELLATION POLICY & FEES AGREEMENT

Your appointment time is reserved for you. If you fail to cancel a scheduled appointment, you will be billed for your missed appointment. A cancellation fee of $50 is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency.
A bill will be mailed directly to all clients who do not show up for, or cancel an appointment. Thank you for your consideration regarding this important matter. There is a $50 fee charged for returned checks, in which the session is then agreed to be paid by cash or credit.

____
Client Signature (Client's Parent/Guardian if under 18)

____
Today's Date