THE CARRUTH CENTER
AT THE PARISH SCHOOL

Play Therapy
2016-2017
Intake Packet

- **Case History**
- **Authorization for Medical Attention**
- **Consent forTreatment**
- **Play Therapy Payment Contract & Authorization**
- **Carruth Center Policies**
- **Release of Information**
- **Schedule of Fees**

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Date:_____ Information provided by:_____

GENERAL INFORMATION

CHILD:_____
First Middle Last Name Called

Address:_____

Birth Date:_____Age:_____ Gender:_____Ethnicity:_____

SS#:_____Who has legal custody of this child?_____

PLEASE NOTE IF CHILD IS NOT LIVING WITH BOTH BIOLOGICAL PARENTS, BOTH ADOPTIVE PARENTS, OR ONLY LIVING PARENT, THE CARRUTH CENTER REQUIRES A COPY OF THE LEGAL DOCUMENT STATING CUSTODY ARRANGEMENTS.

Who referred you to The Carruth Center:_____

May we thank who referred you to us (your identity will not be revealed): ☐ Yes ☐ No

MOTHER/PARENT 1: _____Date of Birth:_____

SS#:_____Race/Ethnicity:_____

Home Address:_____
(if different) City State Zip Code

Contact Information:

Home#:_____May we leave message? ☐ Yes ☐ No

Work#:_____May we leave message? ☐ Yes ☐ No

Cell#:_____May we leave message? ☐ Yes ☐ No

Email:_____May we contact you via email? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Remarried

Education:_____Occupation:_____Place of Occupation:_____

Business Address:_____

FATHER/PARENT 2:_____Date of Birth:_____

SS#:_____Race/Ethnicity:_____

Home Address:_____
(if different) City State Zip Code

Contact Information:

Home#:_____May we leave message? ☐ Yes ☐ No

Work#:_____May we leave message? ☐ Yes ☐ No

Cell#:_____May we leave message? ☐ Yes ☐ No

Email:_____May we contact you via email? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Remarried

Education:_____Occupation:_____Place of Occupation:_____

Business Address:_____

LIVING ARRANGEMENTS

Please list the occupants of your child's:

Custodial Household:_____ (Name of Parent)

Name	Age	Relationship to child

Secondary Household:_____ (Name of Parent)

Name	Age	Relationship to child

Does either parent have children from other relationships not living in the home? If so, please list names & ages below:

Mother/Parent 1: _____

Father/Parent 2: _____

What languages are spoken in your child's home(s)?_____

Is this child adopted? ☐ Yes ☐ No

If YES, at what age?_____ Is he/she aware of this? ☐ Yes ☐ No

Are you divorced/separated? ☐ Yes ☐ No

If YES, at what age?_____ Is he/she aware of this? ☐ Yes ☐ No

List other professionals (speech/language pathologists, PPCD, psychologists, psychiatrists, counselors, neurologists, tutors, OT, educational diagnosticians, etc.) your child has <u>seen in the past or is currently seeing</u>:

Name	Dates Under Care	Reason for Seeing

CURRENT CONCERNS

Please check below any current concerns you have about your child in these areas. Indicate the severity of the problem(s) or concern(s) using the following rating system:

1 Not Severe; 2 Slightly Severe; 3 Moderately Severe; 4 Very Severe; 5 Extremely Severe

☐ Aggression
☐ Appetite changes
☐ Awareness of differences
☐ Difficulties with transitions
☐ Feeding issues/concerns
☐ Hears/sees things others do not
☐ Low frustration tolerance
☐ Noncompliance
☐ Perpetrator of teasing/bullying
☐ Sadness/Depression
☐ Self-stimming
☐ Stealing
☐ Tics
☐ Victim of teasing/bullying

☐ Alcohol/Drug use
☐ Attention seeking
☐ Developmental delays
☐ Distractibility
☐ Harms animals
☐ Hyperactivity
☐ Low self-esteem
☐ Obsessive thoughts
☐ Phobias
☐ Selectively mute
☐ Sexualized behavior
☐ Social Isolation
☐Tantrums

☐ Anxiety
☐ Avoidance
☐ Difficulties separating
☐ Eats non-food items
☐ Harm to othersthoughs
☐ Impulsivity
☐ Lying
☐ Oppositional behavior
☐ Pulls hair out
☐ Self-Harm thoughts
☐ Short attention span
☐ Suicidal Thoughts
☐ Toileting issues (difficulty potty training; withholding, relieving self in unusual places, etc.)

Please explain/list any additional concerns about your child: _____

When did these problems begin? _____

Does your child exhibit any behaviors that you consider 'odd' or 'unusual'?_____

What do you enjoy most about your child?_____

What are your child's strengths?_____

What do you find most difficult about your child?_____

Where does your child struggle?_____

_____

What are your goals for your child's counseling?_____

_____

What might stand in the way of achieving these goals?_____

_____

CHILD'S EMOTIONAL AND BEHAVIORAL HISTORY

Has your child ever had a neurological or psychological evaluation (date, practitioner, and results)?_____

_____

Please describe the frequency of the following characteristics in terms of whether the behavior occurred in the past but no longer occurs, never, sometimes or often occurs:

	Past	Never	Sometimes	Often
Is your child happy?	☐	☐	☐	☐
Is your child affectionate?	☐	☐	☐	☐
Is your child active?	☐	☐	☐	☐
Is your child loud or noisy?	☐	☐	☐	☐
Does your child have difficulty making transitions?	☐	☐	☐	☐
Is your child sensitive to changes in routine?	☐	☐	☐	☐
Is your child resistant to change?	☐	☐	☐	☐
Does your child cry easily?	☐	☐	☐	☐
Is your child distracted/day-dreamy?	☐	☐	☐	☐
Is your child withdrawn?	☐	☐	☐	☐
Is your child irritable?	☐	☐	☐	☐
Is your child clingy?	☐	☐	☐	☐
Is your child attention seeking?	☐	☐	☐	☐
Is your child easily frustrated?	☐	☐	☐	☐
Does your child give up easily?	☐	☐	☐	☐
Can your child entertain/play by him/herself?	☐	☐	☐	☐
Does your child struggle with perspective-taking?	☐	☐	☐	☐
Does your child have issues related to toileting?	☐	☐	☐	☐
Does your child have issues related to eating/feeding?	☐	☐	☐	☐
Is your child obsessive?	☐	☐	☐	☐
Does your child get angry easily?	☐	☐	☐	☐
Is your child oppositional/non-compliant?	☐	☐	☐	☐
Does your child have temper-tantrums?	☐	☐	☐	☐
Is your child worried?	☐	☐	☐	☐
Does your child not speak in certain situations?	☐	☐	☐	☐
Does your child pull his/her hair out?	☐	☐	☐	☐
Is your child physically cautious?	☐	☐	☐	☐
Does your child lack respect for authority figures?	☐	☐	☐	☐
Does your child get into fights?	☐	☐	☐	☐
Does your child take risks that endanger his/her safety?	☐	☐	☐	☐

Does your child think about hurting self or others? ☐ ☐ ☐ ☐
Is your child is aggressive? ☐ ☐ ☐ ☐
If aggressive, does your child: ☐ hit ☐ bite ☐ kick ☐ destroy property

LIFE EVENTS

Please indicate if your child has experienced or witnessed unique events/traumas

☐ Yes ☐ No Chronic Illness of self or significant person: (name and age at occurrence): _____
☐ Yes ☐ No Death of a pet (name of pet and age at occurrence): _____
☐ Yes ☐ No Death of a significant person (name and age at occurrence): _____
☐ Yes ☐ No Emotional abuse: (by whom and age at occurrence):_____
☐ Yes ☐ No Incarcerated family member (name and age at occurrence):_____
☐ Yes ☐ No Intense or out of ordinary medical experiences/concerns:_____
☐ Yes ☐ No Natural disaster (type and age at occurrence):_____
☐ Yes ☐ No Near-death experience (describe):_____
☐ Yes ☐ No Physical abuse (by whom and age at occurrence):_____
☐ Yes ☐ No Separated from parent (how long and age at occurrence): _____
☐ Yes ☐ No Sexual assault/abuse (by whom and age at occurrence):_____
☐ Yes ☐ No Witness to domestic violence: (by whom and age at occurrence)_____
☐ Yes ☐ No Victim/Witness to traumatic event: (describe):_____
Other:_____
_____
_____

SLEEP HYGIENE

What are your child's sleeping arrangements?
☐ Room alone ☐ With sibling ☐ With parents ☐ With others: _____

Does your child sleep: ☐ Alone ☐ Co-sleep With: _____

Does your child sleep in ☐ Crib ☐ Bed ☐ Other:_____

Describe your child's bedtime routine: _____

Does he/she sleep through the night? ☐ Yes ☐ No
If NO, how many times does he/she awaken at night and for how long? _____
What helps him/her get back to sleep? _____

Does your child have several nightmares a week or night terrors? ☐ Yes ☐ No
If YES, please explain_____

OTHER

Did/Does your child have a special object (blanket, teddy bear, etc.)? ☐ Yes ☐ No
If YES, please describe: _____Is it still in use: ☐ Yes ☐ No

Does he/she have any self-soothing behavior (thumb-sucking, twirl hair, pacifier, etc.)? ☐ Yes ☐ No
If YES, describe:_____

MEDICAL HISTORY

PRENATAL AND EN UTERO

Was this a planned pregnancy?: ☐ Yes ☐ No Fertility issues? _____

Please answer which of the following conditions may have occurred during this pregnancy:

☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Epilepsy
☐ Yes	☐ No	Hospitalization	☐ Yes	☐ No	Illnesses
☐ Yes	☐ No	Infections	☐ Yes	☐ No	Injuries
☐ Yes	☐ No	Operations	☐ Yes	☐ No	Tobacco/Alcohol/Drug Use
☐ Yes	☐ No	Traumatic experience(s)	Other: _____		

Please explain all YES answers: _____

_____

BIRTH

Length of Labor: _____ Type of Birth: ☐ C/Section ☐ Vaginal

Was the baby on time? ☐ Yes ☐ No
If NO, was he/she ☐ Early _____weeks ☐ Late _____weeks

Problems during labor?_____

How much did your child weigh? _____Any other concerns of note:_____

_____

Age of Mother/Parent 1 at birth: _____ Age of Father/Parent 2 at birth: _____

NEO-NATAL

Check if any of the following problems occurred after the child's birth:

☐ Yes	☐ No	Cord around the Neck	☐ Yes	☐ No	Cyanosis (turned blue)
☐ Yes	☐ No	Fever	☐ Yes	☐ No	Floppy
☐ Yes	☐ No	Hemorrhage (Bleeding) in Head	☐ Yes	☐ No	Incubator Care
☐ Yes	☐ No	Infection	☐ Yes	☐ No	Jaundice
☐ Yes	☐ No	Large Ventricles (Hydrocephalus)	☐ Yes	☐ No	Need for Ventilation/Oxygen
☐ Yes	☐ No	Poor Feeding	☐ Yes	☐ No	Trouble Breathing
☐ Yes	☐ No	Vomiting	Other: _____		

Please explain all YES answers:_____

_____

How many days after birth was mother discharged from hospital? _____Child:_____

CHILDHOOD

Child's current physician: _____

Physician's telephone number:_____Child's last physical exam:_____

Please list all medication you child **has taken or is currently taking**, the dosage, and reason: _____

_____

_____

Please describe any concerns about your child's physical health:_____

_____

Please check which of the following your child has had. Note the age, complications and frequency below:

☐ Yes	☐ No	Accidental Poisoning	☐ Yes	☐ No	Allergies
☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Asthma
☐ Yes	☐ No	Bed Wetting	☐ Yes	☐ No	Bowel Problems
☐ Yes	☐ No	Broken Bones/Stitches	☐ Yes	☐ No	Chicken Pox
☐ Yes	☐ No	Coma	☐ Yes	☐ No	Concussions
☐ Yes	☐ No	Convulsions	☐ Yes	☐ No	Ear Infections (How Many?)_____
☐ Yes	☐ No	Excessive Vomiting	☐ Yes	☐ No	Falls Frequently
☐ Yes	☐ No	Floppy	☐ Yes	☐ No	Genetic Anomalies
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Head Trauma
☐ Yes	☐ No	Hearing Problems	☐ Yes	☐ No	Hospitalizations_____
☐ Yes	☐ No	Loss Of Consciousness	☐ Yes	☐ No	Measles
☐ Yes	☐ No	Meningitis (Viral/Bacterial)	☐ Yes	☐ No	Mumps
☐ Yes	☐ No	Persistent High Fever	☐ Yes	☐ No	Pneumonia
☐ Yes	☐ No	Pica	☐ Yes	☐ No	Operations_____
☐ Yes	☐ No	Other Infections:_____	☐ Yes	☐ No	Seizures
☐ Yes	☐ No	Staring Spells	☐ Yes	☐ No	Stool Soiling
☐ Yes	☐ No	Tics	☐ Yes	☐ No	Tremor
☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No	Whooping Cough

Other Medical Complaints/Problems: _____

_____

_____

Please explain all YES answers, including age and treatment for each:_____

_____

_____

_____

_____

_____

_____

_____

_____

CHILD DEVELOPMENT

INFANCY

Please check any of the following that described your child as an infant:

☐ Colic	☐ Cried excessively	☐ Difficult to soothe	☐ Disconnected
☐ Easy to soothe	☐ Bonded/Connected	☐ Failure to Thrive	☐ Feeding problems
☐ Fussy	☐ Reflux	☐ RSV	☐ Sleeping problems
☐ Startled easily	☐ Other_____		

Was your child: ☐ Breast-fed ☐ Bottle-Fed Duration? _____

Describe the circumstances around stopping:_____

EARLY CHILDHOOD MILESTONES

Speech-Language/Social: When did your child do the following (Please list specific age if possible):

Smile	☐ Early	☐ On time	☐ Late	Age: _____
Laugh	☐ Early	☐ On time	☐ Late	Age: _____
Maintain eye gaze	☐ Early	☐ On time	☐ Late	Age: _____
Imitation	☐ Early	☐ On time	☐ Late	Age: _____
Gestures (pointing)	☐ Early	☐ On time	☐ Late	Age: _____
Babbling	☐ Early	☐ On time	☐ Late	Age: _____
Cooing	☐ Early	☐ On time	☐ Late	Age: _____
First words	☐ Early	☐ On time	☐ Late	Age: _____
Could you understand your child's speech by age 2?				☐ Yes ☐ No
Could others understand your child's speech by age 2?				☐ Yes ☐ No
Could your child speak in simple sentences by age 2?				☐ Yes ☐ No
How does your child typically communicate?	☐ Gesture		☐ Words	☐ Sentences
Does your child recite scripts from movies or TV?				☐ Yes ☐ No
Does your child echo or parrot what is said, potentially with limited comprehension?				☐ Yes ☐ No

Please describe any areas of concern (articulation, socialization, receptive language, expressive language, pragmatics, etc.):_____

_____

_____

_____

_____

Fine/Gross Motor: When did your child do the following (Please list specific age if possible):

Roll over	☐ Early	☐ On time	☐ Late	Age: _____
Sit	☐ Early	☐ On time	☐ Late	Age: _____
Crawl	☐ Early	☐ On time	☐ Late	Age: _____
Stand	☐ Early	☐ On time	☐ Late	Age: _____
Walk	☐ Early	☐ On time	☐ Late	Age: _____
Wave Bye-Bye	☐ Early	☐ On time	☐ Late	Age: _____
Toilet Trained (day)	☐ Early	☐ On time	☐ Late	Age: _____
(night)	☐ Early	☐ On time	☐ Late	Age: _____
Use writing utensils	☐ Early	☐ On time	☐ Late	Age: _____
Use eating utensils	☐ Early	☐ On time	☐ Late	Age: _____
Snap	☐ Early	☐ On time	☐ Late	Age: _____
Button	☐ Early	☐ On time	☐ Late	Age: _____
Zip	☐ Early	☐ On time	☐ Late	Age: _____
Tie Shoes	☐ Early	☐ On time	☐ Late	Age: _____
Run smoothly	☐ Early	☐ On time	☐ Late	Age: _____
Climb play equipment	☐ Early	☐ On time	☐ Late	Age: _____
Skip with coordination	☐ Early	☐ On time	☐ Late	Age: _____
Ride a: Tricycle	☐ Early	☐ On time	☐ Late	Age: _____
Training wheels	☐ Early	☐ On time	☐ Late	Age: _____
Two-wheeler	☐ Early	☐ On time	☐ Late	Age: _____

Please describe any areas of concern (i.e., fine or gross motor, balance, sensory)"_____

_____

_____

_____

_____

SOCIAL HISTORY AND INFORMATION

Does child have close relationships with peers?: ☐ Yes ☐ No
If YES, how many: ☐1-2 ☐3-5 ☐5+
If YES, friends are ☐ Younger ☐ Same age ☐ Older

Does child have close relationships with adults?: ☐ Yes ☐ No
If YES, describe:_____

Child prefers to:
☐ Play alone ☐ Play one-on-one ☐ Play in small groups ☐ Play in large group

Please indicate characteristics of your child's social/play behavior:

☐ Annoys Others	☐ Cares About Others' Feelings	☐ Creative
☐ Feels Lonely	☐ Flexible	☐ Isolates/Withdraws
☐ Is Liked By Others	☐ Joins Others' Play Ideas	☐ Lines Up Toys
☐ Makes/Keeps New Friends	☐ Pretends	☐ Problem Solves
☐ Repetitively Plays Same Idea	☐ Restricted Interests	☐ Rigid
☐ Scripts (i.e., Movie Dialogue)	☐ Slow To Warm Up To Peers	☐ Slow To Warm Up To Adults
☐ Spontaneous	☐ Talks About Others' Interests	☐ Talks Only Of Own Interests
☐ Trouble Keeping Friends	☐ Trouble Making Friends	☐ Varied Interests

Please rate your child's understanding of social rules/expectations:

1	2	3	4	5
Does not Understand	*Poorly/ Struggles To Understand*	*Somewhat Understands/ Sometimes Struggles*	*Moderately Well Little Struggle*	*Very Well*

Please rate your child's perspective-taking skills (understanding other's thoughts and/or feelings):

1	2	3	4	5
Cannot/ Does not	*Poorly/ Rarely Struggles/*	*Sometimes/ Irregularly*	*Moderately Well/ Consistently*	*Very Well/ Frequently*

Please rate your child's conversational skills:

1	2	3	4	5
Cannot/ Does Not	*Minimal/ Struggles*	*Somewhat Conversational/ Sometimes struggles*	*Moderately Conversational*	*Very Well/ Successful*

Please rate how your child plays with siblings:

1	2	3	4	5
Cannot/ High Conflict	*Poorly/ Struggles/ Significant Conflict*	*Somewhat Positive/ Moderate Conflict*	*Moderately Positive/ Occasional Conflict*	*Very Positive/ Minimal Conflict*

Please rate how your child plays with peers

1	2	3	4	5
Cannot/ High Conflict	*Poorly/ Struggles/ Significant Conflict*	*Somewhat Positive/ Moderate Conflict*	*Moderately Positive Occasional Conflict*	*Very Positive/ Minimal Conflict*

Please rate how your child tolerates competitive games:

1	2	3	4	5
Cannot/ Refuses To Participate	*Poorly/ Struggles To Participate*	*Somewhat Participates/ Sometimes Struggles*	*Participates Moderately Well/ Few struggles*	*Participates Very Well Few to no struggles*

Please rate how your child shares space/materials/belongings:

Cannot/Refuses	*Poorly/ Struggles Significantly*	*Somewhat Tolerant/Sometimes Struggles*	*Moderately Well*	*Very Well*
1	2	3	4	5

Please rate how your child tolerates peer conflict (i.e, can child problem solve, negotiate for needs, etc.):

Cannot/Refuses	*Poorly/ Struggles Significantly*	*Somewhat Tolerant/Sometimes Struggles*	*Moderately Well*	*Very Well*
1	2	3	4	5

Is your child involved in social/extra-curricular activities? ☐ Yes ☐ No

If YES, describe: _____

_____

How many hours of TV and/or videos does your child watch each day?_____

What are his/her favorites?_____

How many hours per day does your child spend on the iPad (or similar) and videogames?_____

What Apps/Games does your child play?:_____

How many hours per day does your child spend on the computer/internet?_____

What sites does your child visit?_____

Is your child involved with social media (Facebook, Instagram, Tumblr, etc.)? ☐ Yes ☐ No

If YES, which ones?_____

EDUCATIONAL HISTORY AND INFORMATION

Name of current school placement:_____

Current Grade:_____ In your child's classroom, what is the number of: Teachers_____

Assistants_____

Students_____

Please list your child's previous schools and corresponding approximate ages

Day Care: _____

Preschool:_____

Elementary School:_____

High School: _____

Please check below if you have concerns about your child at school:

☐ Academic problems	☐ Anxiety	☐ Attention difficulties
☐ Discipline problems	☐ Isolated	☐ Learning difficulties
☐ Speech/language issues	☐ Social difficulties	☐ Unpopular/teased

☐ Other: _____

_____

Has he/she repeated any grades? If so, which?_____

Has your child had special help through the school?_____

How does he/she child feel about school?_____

Do you think your child's teacher likes him/her?_____

Does the teacher describe your child with any of the following comments (please check):

	Past	Never	Sometimes	Often
Cannot follow directions	☐	☐	☐	☐
Cannot complete tasks	☐	☐	☐	☐
Cannot sit still	☐	☐	☐	☐
Doesn't have friends	☐	☐	☐	☐
Doesn't seem to comprehend what's said	☐	☐	☐	☐
Has difficulty expressing thoughts	☐	☐	☐	☐
Is aggressive	☐	☐	☐	☐
Is performing below his/her potential	☐	☐	☐	☐
Is sneaky	☐	☐	☐	☐
Picks on other children	☐	☐	☐	☐
Seems to be daydreaming	☐	☐	☐	☐

FAMILY HISTORY

Please check YES or NO for each of the conditions below that apply to a family member and list relationship to child (e.g., mother, brother, aunt, paternal/maternal grandparent).

☐ Yes ☐ No Heart Problems_____ ☐ Yes ☐ No Birth Defects_____
☐ Yes ☐ No Cancer_____ ☐ Yes ☐ No Cerebral Palsy _____
☐ Yes ☐ No Diabetes_____ ☐ Yes ☐ No Intellectual Disability_____
☐ Yes ☐ No Kidney Disease_____ ☐ Yes ☐ No Obesity_____
☐ Yes ☐ No Seizures_____ ☐ Yes ☐ No Sudden Death_____
☐ Yes ☐ No Thyroid _____ ☐ Yes ☐ No Vision/Hearing Problems_____
Other:_____

_____

Please check YES or NO for each of the conditions below that apply to a family member and list relationship to child (e.g., mother, brother, aunt, paternal/maternal grandparent). Please indicate if any have been particularly impactful to your child.

☐ Yes ☐ No Abuse history_____ ☐ Yes ☐ No ADD/ADHD_____
☐ Yes ☐ No Addiction_____ ☐ Yes ☐ No Anxiety _____
☐ Yes ☐ No Alcoholism_____ ☐ Yes ☐ No Autism_____
☐ Yes ☐ No Bed wetting after 5 y.o._____ ☐ Yes ☐ No Bipolar_____
☐ Yes ☐ No Depression_____ ☐ Yes ☐ No Emotional problems_____
☐ Yes ☐ No Eating Disorders/Problems (describe)_____
☐ Yes ☐ No Learning Disorder/Problems(describe)_____
☐ Yes ☐ No Nervous breakdown_____ ☐ Yes ☐ No OCD_____
☐ Yes ☐ No Phobias_____ ☐ Yes ☐ No Post-Partum Depression_____
☐ Yes ☐ No Schizophrenia_____ Other:_____

_____

FAMILY CULTURE AND PARENTING

Describe any cultural aspects or considerations that are important to your family (i.e, culture of origin, beliefs, values, etc.):_____

_____

_____

_____

Circle the number that best describes how you view your child's current family atmosphere:

Leniency/Strictness:

Very Lenient	*Somewhat Lenient*	*Somewhat Strict*	*Moderately Strict*	*Very Strict*
1	2	3	4	5

Religion/Spirituality:

Very Non-religious	*Somewhat Non-religious*	*Somewhat Religious*	*Moderately Religious*	*Very Religious*
1	2	3	4	5

Structure:

Very Unstructured	*Somewhat Unstructured*	*Somewhat Structured*	*Moderately Structured*	*Highly Structured*
1	2	3	4	5

Expectations:

Low Expectations	*Few Expectations*	*Some Expectations*	*Moderate Expectations*	*High Expectations*
1	2	3	4	5

Consistency:

Very inconsistent	*Somewhat Inconsistent*	*Somewhat Consistent*	*Moderately Consistent*	*Highly Consistent*
1	2	3	4	5

Please indicate the extent to which your family has support systems (such as friends, relatives, other collaborative communities, etc.):

No Support	*Very Little Support*	*Some Support*	*Adequate Support*	*Considerable Support*
1	2	3	4	5

What, if any, religious/spiritual affiliations or memberships does your family subscribe to:?_____

_____

How does your child get along within the family circle?_____

_____

What chores/tasks is your child responsible for around the home? _____

_____

What methods of discipline are used at home?

☐ Avoidance of child ☐ Physical punishment ☐ Removal of privileges
☐ Rewards ☐ Time out ☐ Verbal reprimands
☐ Other _____

What are your child's reactions to discipline?_____

_____

Who is usually responsible for discipline?_____

_____

How would you describe the effectiveness of parenting strategies in your home? _____

_____

_____

How do you feel about yourself as a parent?_____

_____

_____

Please explain any parenting concerns that you have: _____

_____

_____

Are you currently involved in a custody dispute? ☐ Yes ☐ No

If YES, please explain:_____

If divorced/separated, how often does your child see the non-custodial parent?_____

If divorced/separated from your child's other parent, circle which number best describes your relationship with that parent:

Very Hostile	*Somewhat Hostile/ Frustrating*	*Sometimes Frustrating/ Sometimes collaborative*	*Somewhat Friendly/ Somewhat Collaborative*	*Very Friendly/ Collaborative*
1	2	3	4	5

Please use this area for any additional comments or concerns: _____

THE CARRUTH CENTER
AT THE PARISH SCHOOL

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

Child's Name (Print):_____ Date of Birth:_____

Mother's Home #:_____
Mother's Work #:_____
Mother's Cell #:_____

Father's Home #:_____
Father's Work #:_____
Father's Cell #:_____

In the event that we cannot be reached to make arrangements for emergency medical attention, we authorize Karen Dickerson, Clinical Director, or a designated staff member to take my child to:

Doctor _____
Address _____
_____
Phone # _____

Or to the nearest hospital, and we give our consent for any and all necessary treatment. In case of emergency treatment, please inform the medical staff that our child has the following allergies and that our child takes the following medication(s) on a daily basis (include dosage):

_____

_____

_____

Please list two (2) persons whom we may contact in the event of any emergency:

_____ _____ _____
Name Phone Relationship

_____ _____ _____
Name Phone Relationship

_____ _____
Mother's signature Father's signature

_____ _____
Child's Name & Birth date (please print) Date of signatures

THIS FORM MUST BE KEPT UPDATED AT ALL TIMES.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Consent for Play Therapy Treatment

Client:_____ Date of Birth:_____

Parent/Guardian:_____ Relationship to Client:_____

I, _____, hereby give consent for the above named child and/or myself to receive services through Haley Garth, LPC, RPT, NCC at the Carruth Center of The Parish School. This consent is given until I give notice that these services are no longer requested or until Carruth Center of The Parish School professionals notify me these services will no longer be provided. I certify that I have legal responsibility for this child and am authorized to seek and consent treatment for him/her. I understand that all information provided to Carruth Center of The Parish School professionals is confidential and will generally be released to others only with my written consent. I understand that Carruth Center of The Parish School professionals are required to disclose confidential information without my consent in certain circumstances which includes, but is not limited to, 1) if is determined there is a probability of imminent physical injury by my child to himself/herself or other(s), or if there is a probability of immediate mental or emotional injury to my child
2) if the disclosure is required or authorized by law, legal proceedings, or court order 3) to qualified individuals, corporations, or governmental agencies involved in paying or collecting fees for mental or emotional health services for my child 4) to other professionals and personnel, under the direction of Carruth Center of Parish School professionals providing services to my child, who participate in the diagnosis, evaluation, or treatment of my child 5) a judicial or administrative proceeding brought against Carruth Center of The Parish School professionals by myself or my child 6) in the event it is believed my child is the victim of physical abuse, sexual abuse, or neglect, or if my child divulges information about the physical abuse, sexual abuse, or neglect of a child, elder, or disabled person.

The professionals rendering services through Carruth Center of The Parish School are dedicated to using established and empirically supported psychological, behavioral, and educational evaluation and intervention procedures to optimize the social, emotional, and cognitive development of each child. In the event a child presents as an immediate danger to himself/herself, others, or property, the least restrictive intervention shall be utilized to provide safety for the child, others, or property. While verbal mediation will be the primary intervention utilized, at times physical contact may be required to provide safety for the child, others, or property. At these times, a "therapeutic hold" will be used to help manage a child's behavior until verbal mediation can effectively be used to address the situation and/or until the child no longer presents as an immediate danger to himself/herself, others, or property.

My signature on this document indicates I have read the above information and have a clear understanding of the procedures, policies, and therapeutic interventions described. I have been given the opportunity to have my questions answered regarding the above-described information. I understand that I have the right to withdraw treatment for my child at any time.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Date

THE CARRUTH CENTER
AT THE PARISH SCHOOL

PAYMENT CONTRACT & AUTHORIZATION
Play Therapy

Client's (Childs) Name: _____

The fees for the Play Therapy sessions are invoiced on or around the **5th** day of the month following the last session of the previous month. Payment for these sessions will be direct debited from your account or charged to your credit card on or around the **15th** day of the following month (or the next business day), depending on the selection below and payment authorization information provided.

Clinical Intake is $200.00 for an hour session.

Individual / Family therapy is $140.00 per hour session. Family and/or individual sessions cost $140 per therapeutic hour. A standard therapeutic hour for adults is fifty minutes and a standard therapeutic hour for a child (under age 12) is 45 minutes.

_____ Please charge my **credit card** (complete the credit card authorization on following page).

_____ Please **direct debit** my account (complete the ACH direct debit on following page).

In consideration for the acceptance and enrollment of _____ in individual treatment, or group program, I (we) the undersigned parent(s), and/or guardian, or other endorser hereof, promise to pay to the order of Carruth Center, Inc. all applicable fees charged for services rendered due on/or before the fifteenth of the month following treatment. Outstanding balances may result in suspension of services until total account balance has been cleared. There will be a $20.00 service charge for NSF checks.

_____I understand that the form or payment on file must be kept current. To update your form of payment on file, submit a new "Payment Contract & Payment Authorization" form to the Carruth Center, Inc. Business Office before the 15th of the month.

_____I authorize the Carruth Center, Inc. to charge the agreed upon credit card or ACH debit on or around the 15th of each month for services provided during the previous months (generally on going individual services) OR on the dates specified in the payment option selected on the signed contract for services (generally group therapy).

_____I agree that if initial payment processing is declined for any reason, Carruth Center, Inc. may continue to process the payment against the card on a regular basis, until the payment is successfully processed and the balance is resolved. Reoccurring payment declines will result in payments being due at the time of service. In this circumstance acceptable form of payment would be exact cash or a credit card that can be successfully processed at the time of service.

_____I acknowledge and understand the cancellation, late arrival, and late pick-up policies. See Carruth Center Policies form.

See reverse side for payment authorization form
Carruth Center, Inc. must have a current form of payment on file for all clients.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

PAYMENT CONTRACT & AUTHORIZATION

Client's (Childs) Name: _____

Credit Card Authorization

_____ Visa _____ MasterCard _____ American Express _____ Discover

Credit Card Number: _____

Expiration Date: _____ Card Security Code (CSC): _____

Name on Card: _____

Address: _____

_____

ZIP Code: _____

Phone Number: _____

ACH Direct Debit Authorization

_____ Checking Account _____ Savings Account

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

_____I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Attach a blank voided check

This Authorization is to remain in full force and effect until Carruth Center, Inc. has received written notification from me (I or either of us) of its termination in such time and in such manner as to afford Carruth Center, Inc. and DEPOSITORY a reasonable opportunity to act on it.

Print Name: _____

Date: _____ Signature: _____

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Carruth Center Policies

Client's (Childs) Name: _____

Please read carefully. **Both parents or guardians** are required to initial each line.

___ ___ **Clinic Visitation Policy:**

- Children must be accompanied by an adult in the lobby at all times.
- Please check in with Carruth Center, Inc. office before entering the therapy area. All parents and visitors must wear a visitor badge while in the Carruth Center, Inc. therapy area.
- Group observations must be scheduled through the Carruth Center, Inc. business office at least 24 hours in advance.

___ ___ **Cancellation Policy:**

The undersigned hereby acknowledges that failure to cancel a scheduled treatment session or a parent conference 24 hours in advance of the scheduled appointment will result in a 100% charge for the allocated session fee. Carruth Center, Inc. administration reserves the right to dismiss a client from therapy for inconsistent attendance. In addition, the undersigned hereby acknowledges that Carruth Center, Inc. reserves the right to withhold all test results and reports when professional fees are not paid as per above.

- **No show/no call cancellation**: The undersigned hereby acknowledges that failure to notify the treating clinician to cancel a scheduled treatment session will be considered a no show/no call appointment. We ask that all cancellations, not due to illness or a family emergency be made 24 hours in advance.
  A no show/no call appointment will result in a 100% charge for the allocated session fee.
- **Late Cancellation**: The undersigned hereby acknowledges that any cancellation, not due to illness or family emergency, that is made **less** than 24 hours in advance is considered a late cancellation. A late cancellation will result in a 100% charge for the allocated session fee.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

___ ___ **Late Pick-up Policy:**

The undersigned hereby acknowledges that parents are expected to be in the Carruth Center, Inc. lobby or front porch area prior to the end of their child's therapy session. Carruth Center, Inc. late-pick up policy is as follows:

- Client families will be given 2 "passes" (no charge assessed) per fiscal year (August 1st - July 31st) for unexpected tardies not to exceed 5 minutes.
- Late pick-ups **BEYOND** 5 minutes **OR** post 2 "passes" will be charged per the quarter-hour at the standard individual therapy rate.
- Chronic tardiness may lead to parent being required to remain present on campus throughout therapy session.

Breakdown of Late Fees according to therapy discipline

Standard Speech, OT, Music Individual Therapy Sessions	**Standard Individual Therapy Rate ($130.00)**	**Standard Mental Health Individual Therapy Sessions**	**Standard Mental Health Individual Therapy Rate ($140.00)**
5-15 minutes	$32.50	5-15 minutes	$35.00
15-30 minutes	$65.00	15-30 minutes	$70.00
31-45 minutes	$97.50	31-45 minutes	$105.00
46 – 60 minutes	$130.00	46 – 60 minutes	$140.00

*standard mental health therapy hour is 45 minutes for children, and 50 minutes for adults)

- Late fees will be included in the monthly invoice. Failure to resolve fees with regularly scheduled, monthly payment processing, on or around the 15th of every month, will result in suspension of client services.
- Late pick up fees are not eligible for insurance reimbursement.

___ ___ **Late Start Policy:**

The undersigned hereby acknowledges that late arrivals will not be accommodated by extension of therapy time. Full session fee will apply to late arrivals. For example: If a client is 5 minutes late to their scheduled appointment time, the result will be a 30-minute session fee, even though it was only a 25-minute therapy session.

- Clients are encouraged to arrive to the Carruth Center, Inc. lobby 2 to 5 minutes prior to their scheduled session time.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

___ ___ **Policy on Insurance:**

- Carruth Center, Inc. is a fee-for-service facility and families are responsible for all payments.
- Carruth Center, Inc. does not guarantee coverage and/or the ability to gain coverage of services. Coverage is determined by your individual policy.
- Carruth Center, Inc. is considered out-of-network, and therefore, we ask that families act as the liaison for any direct communication with their insurance companies.
- Carruth Center, Inc. does not submit claims on behalf of the client.
- Carruth Center, Inc. provides invoices and or services provided forms with necessary codes, clinician information, and clinic information for your convenience and ease of filing claims.
- Carruth Center, Inc. does not accept payment from insurance companies. All insurance checks issued to the Carruth Center, Inc. are returned to the insurance company with a request to issue payment to the insured. The insured is then notified by letter and copy of the check for their records.

Parent Name (Print): _____ Date: _____

Signature: _____

Parent Name (Print): _____ Date: _____

Signature: _____

THE CARRUTH CENTER
AT THE PARISH SCHOOL

AUTHORIZATION FOR REQUEST/RELEASE OF INFORMATION

Child's Name: _____

I hereby authorize:

Randi Raizner, PhD.	_____ initial to consent
Carruth Center, Inc.	_____ initial to consent
The Parish School	_____ initial to consent

I hereby give permission to The Carruth Center for the following:

_____ In order to process a claim for benefits, I authorize the Carruth Center, to release to my insurance carrier any information regarding my child's medical history, symptoms, treatment, examination results, or diagnosis. Termination of consent must be submitted in writing.

Occupational Therapy REQUIRES Physician's name: _____

Below are listed the person(s), agencies and schools that the assigned individuals or company may contact:

	Name	Address	Telephone #	Fax #
1.	_____			
2.	_____			
3.	_____			

I understand any information obtained is strictly confidential and privileged.

_____ _____
Date Parent or Legal Guardian

A copy of this instrument is as valid as the original.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

PLAY THERAPY SERVICES (Master's Level)
Schedule of Fees

CLINICAL INTAKE – INITIAL INTERVIEW: $200.00 (flat fee)

PHONE CONSULTATIONS: $140 per hour

INDIVIDUAL THERAPY: $140 per hour

GROUP THERAPY: $110 per hour

FAMILY THERAPY WITH PATIENT: $140 per hour

FAMILY THERAPY WITHOUT PATIENT: $140 per hour

FEEDBACK SESSIONS/CONFERENCES: $140 per hour

INSERVICE TRAINING OFF SITE: $300 (first 1.5 hrs flat fee)/$140 each hour

COURT APPEARANCE: $500 (flat retainer) & $250 per hour 3rd hour and beyond