Play Therapy 2015-2016 Intake Packet

- **Case History**
- **Authorization for Medical Attention**
- **Consent to Treat**
- **Payment Contract**
- **Payment method credit/debit card on file form**
- **Release of Information**
- **Schedule of Fees**

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 seen in the past or is currently seeing:

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 Hospitalization
☐ Yes ☐ No Infections
☐ Yes ☐ No Operations
☐ Yes ☐ No Traumatic experience(s)
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Illnesses
☐ Yes ☐ No Injuries
☐ Yes ☐ No Tobacco/Alcohol/Drug Use
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 Fever
☐ Yes ☐ No Hemorrhage (Bleeding) in Head
☐ Yes ☐ No Infection
☐ Yes ☐ No Large Ventricles (Hydrocephalus)
☐ Yes ☐ No Poor Feeding
☐ Yes ☐ No Vomiting
☐ Yes ☐ No Cyanosis (turned blue)
☐ Yes ☐ No Floppy
☐ Yes ☐ No Incubator Care
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Need for Ventilation/Oxygen
☐ Yes ☐ No Trouble Breathing
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:

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

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

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

Please rate your child's conversational skills:

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

Please rate how your child plays with siblings:

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

Please rate how your child plays with peers

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

Please rate how your child tolerates competitive games:

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

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: ____________________________________

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

Child's Name (Print):___________________ Date of Birth:_________________________

Mother's Home #:_____________________ Father's Home #:______________________
Mother's Work #:_____________________ Father's Work #:______________________
Mother's Cell #:_______________________ 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.

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

PAYMENT CONTRACT FOR PLAY THERAPY

Client's Name:_____________________________________

The fees for Play Therapy sessions are billed following the last session of the month. Payment for these sessions will be direct debited from your account or charged to your credit card on the fifteenth day of the following month (or the next business day) depending on the selection below and documentation 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.

Person to be billed:

Name: ____

Address: ____

____

Telephone #: ____

_______ Please **direct debit** my account (complete the ACH Direct Debit form)

OR

_______ Please charge my **credit card** (complete the Credit Card Authorization form)

In consideration for the acceptance and enrollment of ____________________________
in individual treatment, I (we) the undersigned parent(s), and/or guardian, or other endorser hereof, promise to pay to the order of Carruth Center all applicable fees charged for services rendered due on/or before the fifteenth of the month following treatment. After the fifteenth day of the month, a late fee of 10% per annum will be charged for the unpaid balance owed. Balances over thirty (30) days delinquent may result in termination of services.

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

________________________ ____________________________________
Date Signature

________________________ ____________________________________
Date Signature

AUTHORIZATION AGREEMENT
FOR CREDIT CARD CHARGES

CLIENT NAME: ____

_____ Visa _____ MasterCard _____ American Express _____ Discover

Credit Card Number: ____

Expiration Date: ___________ Special Code: ________

Name on Card: ____

Address: ____

____

ZIP Code:

____

I authorize the Carruth Center, Inc. to charge the above credit card:

- **on or around the 15th of each month for services provided during the previous months (generally ongoing individual services)**

OR

- **on the dates specified in the payment option selected on the signed contract for services (generally group therapy)**

Declined Payments:

- **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.**

This Authorization is to remain in full force and effect until the 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 the Carruth Center, Inc. and client a reasonable opportunity to act on it.

Name ____

Date ________________ **Signature** ___________________________

AUTHORIZATION AGREEMENT
FOR DIRECT DEBIT

I (we), ______________________________, parent(s) of ____________________, hereby authorize Carruth Center, Inc. to initiate debit entries to my (our) ___checking account/ ___ savings account (select one) indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Depository Name _________________________________ Branch _____________

City _____________________________ State ____________ Zip ______________

Routing Number _____________________ Account Number _________________

ACH Debits will occur on or around the 15th of each month for services provided during the previous months (generally ongoing individual services) OR on the dates specified in the payment option selected on the signed contract for services (generally group therapy).

Attach a voided blank 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.

Name ____

Date ___________________ Signature _______________________________

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.

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

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