HeartLAND COUNSELING℠

A Division of the Center for Rural Psychology

P.O. Box 8071, Elburn IL 60119 630/365-0899

Name of Patient: ____
First (preferred) MI Last

Date of Birth: ____________________ SSN: ____________________ Sex: ☐ M ☐ F

Home Address: ____

City: ____________________ State: ______ Zip: ____________ Township (if known): ____________

Check here if you DO NOT want us to mail your bill to this address: ☐

Home/evening phone: ________________________ Work/Cell phone: ________________________

Check here if you DO NOT want us to leave phone messages: ☐

Marital Status: ☐ Single ☐ Married Spouse's Name: ______________________________

Race: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Native-American ☐ Other ____________

Occupation: ______________________________ Employer: ______________________________

If Patient is a Minor (under the age of 18)

Parent/Guardian Name ______________________________ Home Phone ________________

Employer ______________________________ Work/Cell ________________

Parent/Guardian Name ______________________________ Home Phone ________________

Employer ______________________________ Work/Cell ________________

Party Responsible for billing ______________________________ SSN: ________________

My signature below indicates that I have been informed of, and given the right to review and secure, a copy of your Services Agreement and the HIPPA Notice of Privacy Practices and that I authorize you to use and disclose my protected health information to carry out:

- *Treatment (including direct or indirect treatment by other professionals involved in my treatment)*
- *Obtaining payment from third party payers (e.g. my insurance company, Heartland's billing company)*
- *The day-to-day operation of your practice (e.g. Heartland's office staff and accountant)*

I understand I may revoke this consent, in writing, at any time.
I hereby authorize payment to Heartland Counseling. I understand that I am financially responsible for any charges not covered by my insurance. I authorize the release of any information relating to this claim. I understand that verification of insurance benefits is not a guarantee of payment. (parent/guardian must sign for minor)

Signature______________________________ **Date** ____________

Name: ______________________________

Are there any medical conditions of which we should be aware? (Please include relevant medications)

____

Previous counseling (Please note approximate dates/duration of service and reason for seeking help):

____

Family/Significant Relationships (Please name, age and for spouse, significant other, children, siblings, former spouses and any other significant relationships of which we should be aware):

Name	DOB/Age (if known)	Relationship to you

In Case of Emergency, Notify: ______________________________

Please tell us:

How did you hear about Heartland Counseling? ☐ Pastor ☐ Friend ☐ Family Member ☐ Doctor

☐ School personnel ☐ West Towns/Conley Outreach ☐ Newspaper Ad ☐ Yellow Pages

☐ Brochure from ______________ ☐ Other: ______________

Whom may we thank for referring you to us? ______________________________

May we mail you newsletters or updates? ☐ Yes ☐ No

May we contact you via email? This can be helpful in scheduling and reminding you of appointments.
By giving my email address below I authorize my psychologist/counselor, and/or his or her administrative and clinical staff to contact me and or receive email from me related to my medical records and/or appointments. I understand that the security of email communication cannot be completely guaranteed and that unauthorized individuals could intercept email but I believe the convenience is worth the risk. I will not hold Heartland Counseling responsible if such an invasion occurs

Email address ______________________________

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T:630/365-0899 F:630/365-9150

Child & Adolescent Background Questionnaire

Date: ____________________________
Name of person completing this form:____
Relation to child:____

Identifying Information

Child's name: ____ Gender: ☐ Male ☐ Female
Date of Birth:________________ Age:________
Ethnicity/Race:____
Is there anything about your cultural background that is important for the therapist to know? __________________________
____

Family Composition

Household Members: *Please list all adults and children living full-time or part-time in the home.*

Name	Age	Occupation	Relationship to Child

Marital Status of Parents or Legal Guardians:

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married

Child's Mental Health History

Has the child ever had an evaluation or treatment for behavior or emotional problems?
☐ No ☐ Yes… If yes, please list where it was provided, most recent place first.

#I. Place of service/clinician ___________ Diagnosis given ___________ Dates of Service ___________

Type(s) of service: ☐ Evaluation only ☐ Individual therapy ☐ Family therapy ☐ Medication ☐ Group therapy
☐ Other (please explain) ____

#I. Place of service/clinician ___________ Diagnosis given ___________ Dates of Service ___________

Type(s) of service: ☐ Evaluation only ☐ Individual therapy ☐ Family therapy ☐ Medication ☐ Group therapy
☐ Other (please explain) ____

Child's Developmental History

Please mark all that apply

Did the child's birth mother have any of the following problems during her pregnancy with the child?

☐ Excessive Vomiting ☐ Anemia ☐ High or Low Blood Sugar ☐ Injury to Abdomen
☐ Stress /emotional problems ☐ High Blood Pressure ☐ Use of Cigarettes, Alcohol ☐ Use of Drugs
☐ Infection ☐ Bleeding ☐ Use of medication ☐ Other: ___________________

Did the child's birth mother have any of the following problems during her labor/delivery of the child?

☐ Premature Delivery ☐ Breach / Forceps Delivery ☐ Caesarean Delivery ☐ Infection at Delivery
☐ Yellow jaundice at birth ☐ Birth Injury or Defects ☐ Long Labor ☐ Medication during delivery
☐ Intensive care after birth ☐ "Blue Baby" / Lack of oxygen at birth ☐ Other: ____________________

What was the child's birth weight? _____lbs _____ounces

At what age did the child reach his/her developmental milestones?

Walked at (about)__________ months Said first words at ___________months
Toilet trained by_________ months Said sentences (at least 2 words together ___________months

Nutrition

Would you say, given the child's height, he/she is: ☐ Underweight ☐ Just Right ☐ Overweight
Has the child recently experienced: ☐ Weight Gain ☐ Weight Loss
Do you have concerns about the child's eating habits / preferences? ☐ No ☐ Yes
Do you have concerns about the child's exercise level? ☐ No ☐ Yes

Child's Medical History

Name, Address, and Telephone Number of Pediatrician or Family Doctor:

____

Has the child had any of the following medical problems? *Please mark all that apply*

☐ Allergies ☐ Head Injury ☐ Loss of Consciousness ☐ Seizures
☐ Headaches ☐ Dizzy / Fainting ☐ High/Low Blood Sugar ☐ Trouble seeing
☐ Trouble hearing ☐ High lead level ☐ Stomach/Intestine problem ☐ Heart Problem
☐ Frequent Pain ☐ Liver/Kidney ☐ Lung Problem/Asthma ☐ Other: ____________________

Does the child take any medicine every day? ☐ No ☐ Yes…Name: ____________________
How many hours a night does the child usual sleep? _______ Nap? ____________________
Does the child have any sleep problems? ____________________

Please describe the child's leisure and recreation activities:

____

____

____

Child's School History

School currently attending: ______________________________ Grade: ________________
Has the child ever failed or been held back a grade? ☐ No ☐ Yes…Which one(s)? ____________________
Please describe the child's academic performance: ____________________

____

Does the child receive special education services? ☐ No ☐ Yes… IEP Classification: ____________________
What grade did services begin? ____________________
Has the child ever been tested for learning or language problems? ☐ No ☐ Yes

If yes, where? ______________________________ When? ____________________

Results? ____________________

How well does this child make / keep friends? ____________________

____

____

Consent to Treat a Minor

I, ______________________________ am the parent or legal guardian of ____________________
(parent or guardian) (client)

______ I am aware that limited information may be shared with me regarding the content of the session with my child. I understand that this is important for developing trust between therapist and client.

______I am aware that my therapist is a mandatory reporter and any disclosure of child abuse will be reported to the appropriate child protective service authority. I understand that I will be informed of such reporting and have the opportunity to make the report personally.

______ I am aware that I will be informed of any and all treatment plans and progress on a regular basis.

______ I am willing to play an active role in my child's treatment or participate in my child's therapy session as deemed appropriate by my therapist.

______ I am aware that I may end treatment at any time for any reason.

______ I have been informed of the benefits and risks of treatment and I give this therapist permission to begin treatment.

I have read and understand the above statements or have had the chance to discuss any and all questions I have regarding these statements.

____ ________________
Signature of Parent/Guardian Date

I, the therapist, have discussed the above statements with the child's parent or guardian. There is no reason to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

____ ________________
Signature of Therapist Date

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AUTHORIZATION TO COMMUNICATE WITH PHYSICIAN

At Heartland we attempt to understand the individuals we work with in a holistic manner that considers all aspects of the person. A part of this involves working with medical professionals. We highly value working as a team with medical professionals to ensure that we are aware of any medical difficulties and how these difficulties may be impacting your mental health. This form when completed and signed by you, authorizes me to receive information from your physician and release protected information from your clinical record to your physician.

o Yes. You may communicate about my treatment with the physician listed below.

o No. You may not share information about my treatment

Physician____ Phone ______________________________

Address ____

This authorization shall remain in effect for one year unless otherwise specified. If you would like to specify another date, please fill in expiration date: __________________

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand I have the right to inspect the disclosed mental health information at any time. I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure.

X______________________________ ___________ _________________________________
Signature of Patient (age 12 or over) or representative* Date Printed Name of Patient

X______________________________ ____________
Signature of Witness Date

*If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Notice to receiving agency/person: Under Illinois and federal law you may not redisclose any of this information unless specifically authorized by above responsible party