Triad Counseling & Clinical Services, PLLC
5587 D Garden Village Way, Greensboro, NC 27410
1623 York Avenue, Suite 104, High Point NC, 27265

Client (Under 18 years old) Information Form

If parent/guardian is completing this form please answer questions from your child's perspective

Date: _____ Full Name: _____

Preferred Name:_____ Who referred you? _____

Date of Birth: _____ Age: _____ Gender: _____ Social Security #: complete in person - do not email

Address: _____

City: _____ State: _____ Zip: _____

Primary Contact Number: (____) _____ Secondary Contact Number: (____) _____

Email Address: _____

Please indicate where we have permission to leave a message: ☐ primary phone ☐ secondary phone

Please choose one (1) option for your appointment reminder:

- ○ voicemail (_____)_____
- ○ text (___)_____
- ○ email _____
- ○ No Reminder Needed

Please indicate you have read:

☐ I understand that email and texting, while confidential, may not be secure to third-party intrusion.

Parent/Guardian 1 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Employer: _____

Email: _____

Home Phone: (_____) _____Work Phone: (_____) _____ Cell Phone: (_____) _____

Please indicate where you prefer to be contacted: ☐home phone ☐work phone ☐cell phone ☐email

Please indicate where we have permission to leave a message: ☐home phone ☐work phone ☐cell phone ☐ email

Parent/Guardian 2 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Employer: _____

Email: _____

Home Phone: (_____) _____Work Phone: (_____) _____ Cell Phone: (_____) _____

Please indicate where you prefer to be contacted: ☐home phone ☐work phone ☐cell phone ☐email

Please indicate where we have permission to leave a message: ☐home phone ☐work phone ☐cell phone ☐ email

Client Education/Employment

Current Grade: _____ School: _____

Employment: ○None ○Part-Time ○Full-Time Occupation: _____ How Long? _____

Afterschool Activities (if any): _____

Family History

Please list information about client's immediate family members:

Relative (mother, father, siblings)	**Name**	**Age**	**Deceased?** (yes/no)	**Current City, State**	**Relationship** (excellent, good, fair, poor)	**Physical/Mental Illness**

Any other family history of psychological/psychiatric concerns? (i.e. grandparents, aunts/uncles, etc.)? _____

_____

Are the clients parents married? ○Yes ○No

If no, please indicate parents relationship status: ○Never Married ○Separated ○Divorced ○Widowed

If no, mother remarried? ○Yes ○No Father remarried? ○Yes ○No

Stepfather/Stepmother Name(s): _____

What are the current living arrangements for the client?: _____

_____

If there is a custody agreement, who has primary custody? _____

Family Spiritual/Religious Practices (if any): _____

Client Spiritual/Religious Practices (if any): _____

Personal Health History

In general, the client's health is: ○Excellent ○Very Good ○Good ○Fair ○Poor

Client's Physician: _____ Date of last Physical Exam: _____

Client's Psychiatrist (if applicable): _____ Date of last visit: _____

Please indicate if the client has any serious medical conditions and age of onset: _____

_____

Does the client have any allergies?: _____

Does the client have any developmental concerns/differences?: _____

_____

Does the client have any medical conditions that required hospitalization?: ○Yes ○No Please Describe: _____

_____

Has the client been hospitalized for psychiatric or substance abuse issues? : ○Yes ○No

Hospital/Treatment Center: _____

Location: _____ Dates of Treatment: _____

Please list **all** current medications for client:

Medication	Dose	Frequency	Reason for Medication	Prescribing Physician

Please describe the client's previous counseling history:

Dates of Service	Counselors Name	Reason for Services/Outcome

Current Health Information:

Briefly describe your reason for/anticipated outcome in seeking counseling services at this time: _____

_____

_____

TO BE COMPLETED BY PARENT/GUARDIAN:

Which Best Describes The Client?	**Never**	**Sometimes**	**Often**
1. Destroys/destroyed property	☐	☐	☐
2. Is/was unhappy or sad	☐	☐	☐
3. Behavior causes/caused problems in school	☐	☐	☐
4. Has/had temper outbursts	☐	☐	☐
5. Worrying prevents them from doing things	☐	☐	☐
6. Worries/worried about almost everything	☐	☐	☐
7. Has repeated unwanted thoughts	☐	☐	☐
8. Engages in repeated, ritualized behaviors	☐	☐	☐
9. Feels nervous and shaky (dizzy)	☐	☐	☐

Which Best Describes The Client?	Never	Sometimes	Often
10. Feels worthless or inferior	☐	☐	☐
11. Changes mood quickly	☐	☐	☐
12. Difficulty with concentrations	☐	☐	☐
13. Frequent stomach or intestinal distress	☐	☐	☐
14. Difficulty falling asleep	☐	☐	☐
15. Difficulty staying asleep	☐	☐	☐
16. Difficulty at home with siblings	☐	☐	☐
17. Difficulty at home with parents	☐	☐	☐
18. Difficulty at school (academics)	☐	☐	☐
19. Difficulty at school (socially)	☐	☐	☐
20. Difficulty at school (behaviorally)	☐	☐	☐
21. Bullies or has bullied others	☐	☐	☐
22. Is/was bullied by others	☐	☐	☐
23. Has experienced significant weight gain	☐	☐	☐
24. Has experienced significant weight loss	☐	☐	☐
25. Restricts/has restricted eating	☐	☐	☐
26. Engages/has engaged in over exercise	☐	☐	☐
27. Feels angry or irritable	☐	☐	☐
28. Engages/has engaged in self-injury	☐	☐	☐
29. Has experienced suicidal thoughts	☐	☐	☐
30. Has attempted suicide	☐	☐	☐
31. Has experienced homicidal thoughts	☐	☐	☐
32. Do you think your child drinks alcohol?	☐Yes	☐No	
33. Do you think your child smokes marijuana/uses other drugs?	☐Yes	☐No	

If you answered ‘yes’ to question #32, how many alcoholic drinks do you think the client has had in the past week?

_____

If you answered ‘yes’ to question #33, how many days do you think the client has used marijuana and/or other drugs?

_____

Does the client have a history of abuse or trauma? ○Yes ○No Please Describe: _____

_____

Do you have a history of abuse or trauma? ○Yes ○No Please Describe: _____

_____

In the past 6 months, how often have you had to miss school/work due to the physical or mental health concerns of the client? _____

In the past 6 months, how often has your family life been disrupted because of the physical or mental health concerns of the client? _____

What strengths do you believe the client has? _____

_____

_____

How do you think the client would answer the following statements?

I feel good about myself.	○Strongly Agree	○Agree	○Disagree	○Strongly Disagree
I can deal with my problems.	○Strongly Agree	○Agree	○Disagree	○Strongly Disagree
I am able to accomplish the things I want.	○Strongly Agree	○Agree	○Disagree	○Strongly Disagree
I have friends or family that I can count on.	○Strongly Agree	○Agree	○Disagree	○Strongly Disagree

Is there any additional information you think it would be helpful for the therapist to know in providing services to the client? _____

_____

_____

_____

_____

Please initial the following statements regarding payment, release of information, and confidentiality:

_____ I understand that all fees from professional services rendered are my responsibility, including services not covered by insurance. I am aware that this office files my insurance as a courtesy, and services must be paid when rendered.

_____ I hereby authorize Triad Counseling and Clinical Services, PLLC to release any information necessary to process insurance claims concerning my diagnosis and treatment, and I authorize payment of medical/psychological benefits to Triad Counseling and Clinical Services, PLLC.

_____ I understand that Triad Counseling and Clinical Services, PLLC, is ethically and legal required to report to legal authorities information I give about ongoing abuse of children, disabled, and elderly persons and imminent physical danger I present to myself or others because of psychological factors.

_____ _____

Parent/Guardian (on behalf of client) Date

Release of Information

Scheduling or Billing

You can authorize the release of your private health information to others for scheduling or billing purposes. Keep in mind that we cannot discuss your records without your written consent. Please complete the section below if you would like to allow access to your records.

Please initial the following:

_____ I **do not authorize** access to my private health information (PHI) at this time,

OR

_____ I **authorize** access to my private health information (PHI) to the following individual other than the parent or guardian:

Name: _____, Relationship: _____, in the following forms and purposes only:

_____ Scheduling (making, changing, or verifying appointments)

_____ Billing (accessing verbal and written detailing in regards to payments, session dates, and general billing inquiries, including allowing others to make payments on my behalf)

_____ _____

Parent/Guardian signature Date

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CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & ACKKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information" or PHI), excluding psychotherapy notes, by Triad Counseling and Clinical Services, PLLC (Provider) in order to carry out treatment, payment, or health care operations (TPO). My specific authorization must be obtained for disclosure of my PHI, including summary of psychotherapy notes, for purposes other than TPO, except in special situations. I have reviewed the Notice of Privacy Practices for a more complete description of the potential disclosures of such information.

I have the right to inspect and obtain a copy of my medical/mental health records, although I understand the Provider has the right to deny such request under certain circumstances. I have the right to have a denial to inspect reviewed by a "reviewing official." A reasonable fee may be charged for providing a copy of my records. I have the right to request amendments to the information in my medical/mental health records, although I understand the Provider has the right to deny such request. I have the right to request an accounting of disclosures of my PHI for purposes other than TOP and those for which I provided authorization. I may submit a written privacy complaint to 5587 D Garden Village Way, Greensboro, NC 27410 or to the U.S. Secretary of the Department of Health and Human Services, without any action being taken by the Provider against me without any change in my treatment.

Provider reserves the right to change the terms of its Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed, I may obtain a copy of the revised Notice by requesting a copy.

I retain the right to request that the Provider further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Provider is not required to agree to such requested restrictions; however, if the Provider does agree to the requested restriction(s), such restrictions are then binding on the Provider.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Provider in writing. The revocation shall be effective *except* to the extent that the Provider has already taken action in reliance on the Consent.

The Provider may refuse to treat me if I (or authorized representative) do not sign the Consent portion of this form (except to the extent that the Provider is required by law to treat individuals). If I (or authorized representative) sign the Consent portion and then revoke Consent, the Provider has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Provider is required by law to treat individuals).

Please initial the following:

I _____ HAVE HAD AN OPPORTUNITY TO REVIEW THE PROVIDER'S NOTICE OF PRIVACY PRACTICES.

I _____ **CONSENT** TO THE RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

OR

I _____ **DO NOT CONSENT** TO THE RELEASE FOR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____	_____	_____
Please Print Name	Client's Signature (or authorized representative)	Date

Representative's Authority to act on behalf of the Patient: _____

For office staff use only:

Acknowledgement of Privacy Practices was not obtained because: _____

Consent for the Release of Mental Health Information

This form is used to be able to discuss or release information to you (or your child's) primary care doctor only, in order to coordinate treatment.

If you wish for information to be released to the primary care doctor only, please fill in the name of that doctor, check by the authorization line and **sign and date the form**.

If you **DO NOT** wish for information to be released to the primary care doctor, check by the decline line and **sign and date the form**.

Client Name: _____ Date of Birth: _____

Mental Health Provider Name: _____

Address: _____

Phone: _____

Primary Care Physician Name: _____

Address: _____

Phone: _____

____ I authorize the release of relevant treatment information to the provider(s) named above. I understand that these records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. My consent may be revoked at any time, and expires one year from the date signed.

____ I decline the release of treatment information to my Mental Health Provider or Primary Care Physician.

_____ _____

Client's Signature (Parent/Guardian) Date

Relationship to Client: _____

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Parent/Guardian Information Form

Date: _____ Full Name: _____

Date of Birth: _____ Gender: _____ Relationship to Client: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Other Phone: (_____)_____

Email Address: _____

Please choose one (1) option for appointment reminder:

◯ Text (____)_____ ◯ Voicemail (____)_____

◯ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: (____)_____

Is there any parental history of family psychological/psychiatric concerns? If so, please specify: _____

_____

_____

Is there any parental history of alcohol/substance abuse? If so, please specify: _____

_____

_____

Is there any parental history of psychiatric/substance abuse treatment? If so, please specify when and what type:

_____

_____

Is there any parental use of medication for psychological concerns? If so, please specify: _____

_____

_____

Do you think you and your child have different goals for counseling at this time? _____

_____

_____

Late Cancellation and No Show Notice

TCCS client, please note that our no show and late cancellation fee is $125.00. This charge is not billable to insurance, so for a missed appointment it will be the full amount.

Appointments that are cancelled within the 24hr time window are not subject to this fee.

Please make every attempt to keep your appointment or cancel within 24hrs.

Please sign this form to agree that you understand this policy and that you are responsible for this fee if it is assessed to your account.

Thank you,

TCCS Management

Client signature_____Date: _____