BlueSky Children and Family Therapy LLC

Nancy Miller LMHC
Support for Children and Families
125 N Belcher Rd
Clearwater, FL 33765
727-418-2874

General Parent Questionnaire- Child/Adolescent

Note: Please complete all the information on this questionnaire. All information is treated in confidence and will not be released without your permission.

Date_____ Form completed by _____

Child's full name_____
First Middle Last

Date of Birth _____ [ ] Male [ ] Female

Address _____
Street City State Zip

Home Phone _____ Work phone _____ (mother) _____(father)

Cell Phone _____ (mother) _____ (father)

May we leave voice message and/or text messages? Please check your preferences? (cell and home numbers only)

___Yes-voice mail and text messages **or** ___Yes-voice mail only **or** ___Yes – text message only **or** ___No messages

Email _____(mother) _____(father)

Who referred the child? _____
Name Address

Child's Primary Care Physician _____
Name Phone

Family

Father's name_____ Date of Birth _____
First Middle initial Last

Address (if different from above) _____

Occupation_____ Education level_____ # of dependents _____

Mother's name _____Date of Birth _____
First Middle initial Last

Address (if different from above) _____

Occupation_____ Education level_____ # of dependents _____

Date of marriage _____Present marital status _____

With whom does the child live? [ ] Birth parents [ ] Adoptive parents [ ] Foster parents
[ ] Other (specify) _____

If the parents are separated or divorced: Date of separation/divorce _____

Who has physical custody? _____ Who has legal custody? _____

List all other persons living in the home:

Name	Relation to the child	Present health
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any other people who care for the child a significant amount of time:

Name	Relationship to the child (grandmother, neighbor, ect.)
_____	_____

_____ _____

What is your family's or child's ethic or cultural background?

_____
_____
_____

What is your family's or child's spiritual beliefs – background?

_____
_____
_____

Child

Pregnancy and birth: Any complications? [ ] Yes [ ] No; if yes, briefly explain:

_____
_____
_____

Developmental milestones: (Ages) Sitting: _____ Walking: _____ Talking: _____ Toilet-trained: _____

Medical problems: [ ] Yes [ ] No; if yes, briefly explain:_____

_____
_____
_____

Please list any jobs of chores your child/teen has at Home or at school- for example feeding the dog, making the bed, trash, etc. [ ] None

1. _____
2._____
3._____

How well does your child/teen do these jobs/chores?

	Poor		Average		Great
1.	1	2	3	4	5
2.	1	2	3	4	5
3.	1	2	3	4	5

What are your child's strengths? _____

_____

How many close friends does your child have? [ ] None [ ] 1 [ ] 2 or 3 [ ] 4 or more

How many close friends in the neighborhood does your child have? [ ] None [ ] 1 [ ] 2 or 3 [ ] 4 or more

How many times a week does your child do things with them? [ ] None [ ] 1 [ ] 2 or 3 [ ] 4 or more

Compared to other children his/her age, how Does your child get along with other children?

Poor		Average		Great
1	2	3	4	5

What are your child's favorite recreational or extracurricular activities? _____
Who generally disciplines the child? _____
What methods are used?_____
Do parents agree on methods of discipline? [ ] Yes [ ] No; if so, please elaborate:_____
_____
_____

Family Record

Check condition and relationship of any blood relative who has or has had any of the conditions listed below:	Yes **Child**	No **Child**	Being treated	Father	Mother	Grandfather	Grandmother	Brother	Sister	Daughter	Son	Other	Indicative othere relative
Alcoholism/substance abuse													
Allergies													
Birth defects													
Cancer													
Colitis													
Depression													
Heart attack													
High blood pressure													
Liver disease													
Migraines													
Mental illness													
Seizure disorder													
Mental retardation													
Learning disorder													
Attention problems													
Suicide/suicide attempt													
Kidney disease													
Other													

Family member	Living?	Age	Current health			If deceased, reason for death
			Good	Fair	Poor	
Father						
Mother						
Brothers						
Sisters						

Last physical exam due date:_____

School History

Has child been enrolled in a nursery or day care? [ ] Yes [ ] No At what age?_____
Has child attended kindergarten? [ ] Yes [ ] No At what age?_____
Has child begun elementary school? [ ] Yes [ ] No At what age?_____
At what age did he/she enter first grade? _____ What is present grade placement? _____

Grade	School	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current school performance (for children ages 6 and older):
[ ] Does not attend school

	Failing	Below Average	Average	Above average
a. Reading				
b. Writing				
c.Arithmetic/math				
d. Spelling				
Other academic subjects (history, science, foreign language, geography, etc.				
e.				

f.				

Parental Concerns

What do you feel is your child's main problem?

_____

_____

_____

What do you feel caused your child's problem?

_____

_____

_____

What have you been told by doctors, teachers, and/or others about your child's problems?

_____

_____

_____

What have you done to try and deal with your child's problems?

_____

_____

_____

Has your child had any other mental health evaluations or treatment? Have any of your children been diagnosed or treated for a behavioral or developmental disorders or disabilities? (such as ADD/ADHD; learning difficulties; Depression; Autism, etc.)

_____

_____

_____

Has any other member of your child's immediate family had any mental health treatment?

_____

_____

_____

Other comments:

_____

_____

_____

INFORMATION SHEET AND TREATMENT CONTRACT/CONSENT

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable us to work most effectively together, ***please carefully read the information below.*** *If you have any questions, we will be happy to discuss them with you.*

Confidentiality: All communications between the client and the counselor are confidential. Such information will not be released to anyone, including other agencies, without your written consent. However, Florida State Law requires that the therapist report to the appropriate authorities any suspected sexual abuse, physical abuse, neglect of a minor or serious threat of physical harm to self or others. In addition, if a court orders the therapist to testify, the therapist is required to do so. Other exceptions to confidentiality would be if it were necessary to consult with a supervisor or colleague regarding recommendations for treatment. Minors: If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records.
_____ Initial (legal guardian)

Telephone & Emergency Procedures: Should you need to contact the office, our answering system will receive your call 7 days a week, 24 hours a day. When calling, please leave your name and telephone number where you can be reached for a return phone call. Phone calls will be returned within a 24-hour business day period. Weekend calls will be returned on the next business day. In some instances, you might need immediate help at a time when we cannot return your call. These emergencies may involve suicidal thoughts, thoughts of wanting to hurt someone else, or thoughts of committing dangerous acts. If you find yourself in any emergency situation, please visit the nearest ER and ask for a Mental Health Professional or call 911. **We do not provide emergency services**.

_____ Initial (legal guardian)

Emergency and Safety: In the event of an emergency during or after therapy, and the counselor becomes concerned for your safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he/she will do whatever is needed, within limits of the law, to prevent you from injuring yourself or others and to ensure that your receive the proper medical care. For this purpose he/she may also contact the person whose name you have provided as your emergency contact. _____ Initial (legal guardian)

Payment of Services and Insurance: Each counseling session is $80.00 per 50 min session. We ask that payment be made prior your session. Please allow for this in your arrival time. Payment may be made payable to **Nancy Miller LMHC or BlueSky Children and Family Therapy LLC** by cash, check, Visa, MasterCard, American Express, Discover, or Healthy Savings Account. We will file your claim to your insurance company or provide you with the proper information needed for you to file a claim. You are responsible for the timely payment of your Account. We will send information, including clinical information i.e. diagnosis, to your insurance company unless you specifically instruct us not to do so. We will send information electronically, so please read the HIPPA notice. This does not guarantee reimbursement.
_____ Initial (legal guardian)

Late Appointments: We typically schedule clients on the hour. Therefore, it is necessary to be prompt for your session. Counselors will wait 15 minutes for a client. However, if the client chooses to arrive late, only the remainder of the session will be utilized. If for some reason the therapist is running late, the full scheduled session will still be provided. _____ Initial (legal guardian)

Cancellations/No show: Regular attendance will produce the maximum therapeutic benefits. If you must cancel or reschedule, please phone the office at least 24 hours in advance of your scheduled appointment. Our system records the date and time of your call. **The full amount of counseling session fee ($80.00) will be charged for cancellations or missed appointments with less than 24 hours notification**. Services will be discontinued, or a prepayment required, if there are two missed scheduled appointments, or if there are two consecutive late cancellations. Your cooperation in this regard will be greatly appreciated.

_____ Initial (legal guardian)

Dual Relationships: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves any dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some areas multiple relationships are unavoidable. The counselor will never publically acknowledge working with you without written permission. Neither will you be accepted as a client if the counselor feels there is a significant dual or multiple relationship in existence. It is your responsibility to advise the counselor if any such relationship becomes uncomfortable for you in any way. The counselor will always listen and provide feedback and will discontinue the dual relationship if you find it is or may interfere with the effectiveness of the therapy or your welfare and of course you may do the same at any time.

_____ Initial (legal guardian) _____ Minor Initial

Social Networking, Internet Searches, Email Contact, and Text messaging: The counselors of the practice do not accept friend requests from current or former clients on social networking sites such as Facebook. The reason for this is that we believe that adding clients on these sites and or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, we ask that clients do not communicate with the counselors via interactive or social networking sites. You may use texting and email to schedule, confirm, or cancel appointments only (use the initials only to identify yourself or others).Please do not communicate confidential personal information using these modes of communication.

_____ Initial (legal guardian) _____ Minor Initial

Christian Counseling (if applicable): All beliefs are accepted in this center; however, the counselors adhere to the faith that there is only one God who sent His Son, Jesus Christ, to atone for our sins and provide a way for each individual to have a personal relationship with God. The Bible is the infallible, inerrant Word of God. All theoretical stances and theories practiced in this office align with the principles taught in the Bible. References to specific scripture are commonly used in the sessions. Please discuss your comfort level with your counselor regarding any concerns you may have with these practices. ***If you do not wish to have Christian-faith based interventions please leave the initial request blank.***

_____ Initial (legal guardian) _____ Minor Initial

I understand that while the therapy office is located within the offices of Skycrest Community Church, BlueSky Children and Family Therapy LLC -Nancy Miller LMHC is a separate legal entity. Therefore Skycrest Community Church is solely in the role of lessor of office space and in no manner legally associated with this practice.

_____ Initial (legal guardian)

I have read the above information and voluntarily request counseling services with BlueSky Children and Family Therapy LLC- Nancy Miller, LMHC. I agree with these terms and conditions. I have read the Agreement and Office Policies and General Information. I understand them and agree to comply with them. I also acknowledge that I have been given a copy or have access to an electronic copy of HIPPA/Privacy Practices implemented here at BlueSky Children and Family Therapy LLC- Nancy Miller LMHC.

_____	_____	_____
Print Name (Client- minor)	Signature	Date
_____	_____	_____
Print Name (Legal Guardian)	Signature	Date
_____	_____	_____
Print Name (Legal Guardian)	Signature	Date

Insurance: If you will be filing a reimbursement claim with your insurance company, please give the following information, and sign the authorization statement:

Client/Patent's Name: _____

Insurance Company:_____ Phone: _____

Client/Patent's ID:_____

Client/Patent's Date of Birth:_____

Insured's Name (policy holder): _____

Insured's Date of Birth:_____

Authorization #_____ Co-payment:_____

Insurance Authorization

I hereby authorize the release to BlueSky Children and Family Therapy LLC- Nancy Miller LMHC and/or my insurance company of any medical or other information necessary to provide continuity of care and to process insurance claims on my behalf. I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits to myself or the provider(s) named above. I understand that I am responsible for full payment of my counseling fees in the event my insurance company does not pay.

_____	_____
Signature	Date