Counseling Center of Montgomery County

212 Conroe Drive
Conroe, TX 77301

www.CounselingCenterMC.com

CCMC@CounselingCenterMoCo.com

(936) 760-1880 Office
(936) 760-2915 Office
(936) 760-9101 Fax

CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY

Date of Appointment:_____

IDENTIFYING INFORMTATION

Name of Client:			**Gender: Male Female**
Address:			
City:		**State / Zip:**	
Cell Phone:	**Home Phone:**	**Work Phone:**	
Email Address:		**Date of Birth:**	**Age:**
Social Security #:		Medicaid #:	
Current School:		**Previous School:**	
Teacher:		**School Phone Number:**	

Family Information

Mother's Name:_____ D.O.B.:_____ Age:_____

Address :_____

City:_____ State:_____ Zip:_____

Home Telephone Phone: _____ Cell Phone:_____

Work Phone: _____ Email: _____

Father's Name:_____ D.O.B.:_____ Age:_____

Address :_____

City:_____ State:_____ Zip:_____

Home Telephone Phone: _____ Cell Phone:_____

Work Phone: _____ Email: _____

Step-Mother's Name:_____ D.O.B.:_____ Age:_____

Cell Phone: _____ Email: _____

Step-Father's Name:_____ D.O.B.:_____ Age:_____

Cell Phone: _____ Email: _____

CPS Caseworker:	**Phone Number:**
Email Address:	
CASA Caseworker:	**Phone Number:**
Email Address:	
Lawyer(s):	**Phone Number:**
Email Address:	

Current Concerns:

Why are you seeking counseling?

How long have these problems occurred?

Problems perceived to be (Please circle):
Very serious Serious Not serious

What happened that makes you seek help at this time?

What changes would you like to experience?

Have you seen a therapist/psychologist/counselor before? Please explain:

Current Family situation:

Why are you currently living at MCYS?

Is the goal to return to living with your family? Yes No
If yes, who will you live with? _____
When will you return? What are your expectations?

Name of brother / sister	Age	How related? Full / Half / Step / Other	Relationship? Good / Fair / Discord

Please list where you have lived and with whom throughout your life:

HEALTH OF THE FAMILY MEMBERS:

List all the family members by their relation to the client who have a history of depression, ADHD, anxiety, mood disorder, drug/alcohol abuse, behavioral problems, legal problems, or other psychological problems:

Name:	Relation:	Mental Health:	Drugs / Alcohol:	Legal:	Other:

*Please list addition family members on the back of this page

CHILD HEALTH INFORMATION:

Note all health problems the child has had or has now:

Have you ever been admitted to a psychiatric hospital? Yes No
If yes, please explain:

Age Admitted:	How Long:	Reason / Diagnosis:	Recommendations / Medications:

*Please list additional information on the back of this page

Have you ever seen a medical specialist? Yes No
If yes, please explain:

Age:	How Long:	Reason / Diagnosis:	Recommendations / Medications:

*Please list additional information on the back of this page

Have you ever taken or are you taking any prescribed medications? Yes No
If yes, please explain:

Age:	Medication:	Dosage / When taken:	Reason for Medication:	How long:

*Please list additional information on the back of this page

Name of Primary Care Physician(s) Phone Number(s) Address

EDUCATIONAL HISTORY:

Name of School Dates Attended City/State Grades Completed

Are you enrolled in any special education or specially modified classes? _____ Yes _____ No
Explain:

Have you ever been retained or skipped a grade? _____ Yes _____ No
Explain:

Do you attend school on a regular basis? _____ Yes _____ No
Are you motivated for school? _____ Yes _____ No
What are your grades?

What is your favorite class?

Least favorite class?

Have you ever been suspended or expelled? _____ Yes _____ No
Explain:

Do you participate in extracurricular activities? _____ Yes _____ No
Explain:

What are your educational aspirations?

LEGAL HISOTRY:
Have you ever had difficulty with police? Explain:

Have you ever appeared in juvenile court? Explain:

Have you ever been on probation? Explain:

Have you ever used alcohol, tobacco, other drugs, or abuse prescription medication? Explain:

Have you ever been forced to participate in substance abuse classes, tobacco cessation classes, anger management, or other classes per court order? Explain:

EMPLOYMENT:

Have you ever been employed? _____ Yes _____ No

Employer:	When:	Length of Employment:	Reason for Leaving:

OTHER INFORMATION:

What are your hobbies and interests?

What are your strengths and talents?

What is your religion?

What cultural affiliation do you have?

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CONSENT TO SERVICES / RIGHTS ACKNOWLEDGEMENT

CONSENT TO SERVICES

I hereby request and consent to services for myself/dependent which includes therapy, diagnostic assessment, case coordination, consultation, and other treatment/services recommended and considered necessary by Counseling Center of Montgomery County, hereafter referred to as the clinic. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my therapist.

I am aware that I may stop my treatment with my therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment (for example, if my treatment has been court ordered, I will have to answer to the court).

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive at this clinic. I understand that if payments for the services I receive at this clinic are not rendered, then the clinic may stop my treatment.

I understand and have been informed that Licensed Professional Counselor – Interns may be involved with my treatment and sessions.

I have been informed that any information regarding services at Counseling Center of Montgomery County are subject to release only by my informed and written consent or by subpoena and/or court order. I have also been informed that patient identifying information about me may be exchanged between office staff and other designated/contracted providers for continuity of care purposes.

I authorize this clinic to release any medical information necessary to process claims for the services provided. I authorize payment of governmental/medical benefits to this clinic for services provided. I understand that I remain responsible for any and all charges not met by my insurance company.

_____ Initials

CONSENT FOR TREATMENT OF MINOR

I authorize this clinic to provide services for _____. I agree to follow-up with phone conversations regarding progress in therapy and to participate in therapy as recommended.

Client Signature Date

Staff Member Signature Date

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONS ABOUT YOU MAY BE USED AND DISCLOSED AND HOU YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other used required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining authorization for treatment may require that your relevant protected health information be disclosed to the health plan.

Healthcare Operations: We may use or disclosed, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of Licensed Professional Counselor Interns, and licensing. For example, we may call you by a name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your authorization or opportunity to object unless required by lay.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

II. Your Rights

You have the right to inspect and receive a copy of your protected health information. Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on the disclosure of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the

restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. You have the right to have your physician amend you protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

III. Complaints

You may file any complaints with our office staff, at 936-444-3546, or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

I, _____, have read and understand the information contained in the HIPAA Notice of Privacy Practices form.

_____
Initials

Please acknowledge your receipt of this Notice of Privacy Practices by signing below.

Client Signature Date

Staff Member Signature Date