RECOARSE Counseling, PLLC

RECOARSE Integrative Therapies
612 S Creyts Road Suite B, Lansing, MI 48917
(517) 285-0527 (Cell) & (517) 220-4694 (Fax)

All submitted information is confidential. If an item does not apply to you write "NA".

Child and Adolescent History

Name _____ Today's Date _____

Address_____

Date of Birth _____ Place of Birth _____

School _____Grade completed _____

Parent(s)/Guardian_____

Please describe the reason for the appointment_____

_____

Family Information

Parent (s)/Guardian(s) (including step-parents and foster parents) _____

_____

Contact information of non-custodial parent (if available) _____

Please list who can give permission to seek treatment for this child _____

_____

Marital status of responsible parties _____ married _____ never married _____separated _____divorced

Please describe current living situation _____

_____

Siblings names and ages _____

_____

Responsible Party/Insurance information THIS MUST BE FILLED OUT FOR US TO BILL YOUR INSURANCE

Responsible party _____

Address of responsible party: _____

Phone number:_____

Primary Insurance information (please present card)

Insurance:_____Employer_____

Subscriber or enrollee ID number: _____

Policy holder's name: _____DOB: _____

Secondary Insurance information (please present card)

Insurance: _____Employer: _____

Subscriber or enrollee ID number: _____

Policy holder's name: _____DOB: _____

Extracurricular Activities

Does the child participate in extracurricular activities? _____

If yes, please list_____

If client is an adolescent, is he/she currently employed? Yes____

Employer _____ Position _____ Length _____

How would you describe your current work situation? _____

_____

Hobbies/Interests

_____

Describe your child in 3 to 5 words

_____

Medical Information

Primary Care Physician _____ Date of Last Physical _____

List any current medication, dosage, and reason (including vitamins/herbs/over the counter medication) for medication _____

_____

Physical concerns _____Headaches _____Sleep _____ Stomach _____Other

Please explain _____

_____

Were there any problems with the pregnancy or delivery? _____Yes _____No

explain_____

_____

Were there any delays in development? _____Yes _____No

explain_____

_____

Emotional Concerns (Please check any that apply)

_____ Depression _____Anxiety _____ Anger _____Other

_____Nightmares _____Family Problems _____ Stress

_____Acting out sexually _____ Suicidal thoughts or actions _____ Fear

Please explain _____

_____

Is the child currently or has he/she been in the past under the care of another mental health professional (i.e. psychiatrist, psychologist, counselor, etc.)? _____Yes _____No. If yes, please explain

_____

_____

Are any family members currently under the care of a mental health professional (i.e. psychiatrist, psychologist, counselor, etc.)? If yes, please explain_____

_____

Does the child or any family members have any history of depression or other similar problems (i.e. anxiety, manic depression, schizophrenia)? Yes _____No_____. If yes, please explain:

_____

_____

Does the child or any family members have any history of drug/alcohol abuse? _____ Yes ____ No.
explain_____

_____

_____

Is there a history of or is there currently any type of abuse or neglect towards the child? ____Yes ____ No
explain_____

_____

If yes, has this information been reported to the proper authorities? ____Yes ___No. If yes, is there an open case or pending investigation?
explain_____

_____

Has the child had any academic or behavioral problems in school? _____Yes _____No
If yes, please check all that apply

_____poor attention span/excessive fidgeting
_____not able to stay on task/turn in assignments
_____declining/failing grades
_____speech problems
_____multiple detentions/visits to principal's office
_____uncharacteristic behavior
_____arguing/fighting/hitting
_____refuses or unable to follow directions
_____other _____

Have you been told that your child has a learning disability? _____
If yes, please explain

_____

_____

Is there anything that may interfere with counseling? _____

Optional Information

Race and ethnicity _____
Religious Affiliation _____
Other information that you feel might be helpful when providing services

_____

_____

Communication by Email/Texting

_____I disagree with sending or receiving communication through either of these forms of communication, **except for appointment reminders**.

_____I agree with sending or receiving communication through the following:

____ Email- address is: _____

____ Text- phone number is: _____

Notice of Privacy Practices Receipt and Acknowledgment

I, the undersigned, hereby acknowledge receipt of the Notice of Privacy Practices given to me by RECOARSE Counseling, PLLC / RECOARSE Integrative Therapies

Cancellation Policy

I, the undersigned, understand that my therapist respects my time and ask that I respect hers as well. I understand that if I cannot give 24 hours' notice of a cancellation that I may be charged a $50 fee which is payable prior to resuming counseling services. This fee is not billable to my insurance company (third party payer).

Financial Responsibility

I, the undersigned, hereby authorize release of information necessary for RECOARSE Counseling, PLLC / RECOARSE Integrative Therapies to file a claim with my insurance company (third party payer) and assign benefits otherwise payable to me to the provider or group indicated on the claim. I understand that I am financially responsible for any balance not covered by a third party payer, i.e. co-payments, co-insurance, deductibles or non-covered services (may include requested letters written and/or consultations not billable to your insurance company). I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. If it is ever necessary for this office to employ collections counsel, I understand that I am responsible for those collection charges.

Consent to Treat

I verify that the information given is correct and I consent to receiving therapy services. I also agree that a copy of my signature is as valid as an original.

_____Date_____

Signature of client

_____Date_____

Signature of therapist