

Personal Information

Patient's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Address: _____ City, State, Zip: _____

Referred by: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Reminder or cancellation messages due to office emergency can be left at:

☐ Home Phone ☐ Work Phone ☐ Email ☐ Cell Phone TEXTING OK? ☐ yes ☐ no

In the event of an emergency with you, whom should we contact:

Name: _____ Relationship: _____ Work # _____ Home # _____

Person Responsible for Services Rendered

Name: _____ Relationship to Patient: _____

Birthdate: _____ Occupation: _____

Address: _____ City, State, Zip: _____

Employer: _____

Work # _____ Home/Cell # _____ Email _____

ce

X _____

Signature of patient or parent/legal guardian if minor

X _____

Date of signature

Your Child's Education

Name of School: _____ School District: _____ Phone: _____

Main Teacher (or teacher who knows your child best): _____ Current Grade: _____

Placement and Services (current or past)	No	Yes	Describe (e.g. when, which subject failed or grade repeated)
Early Intervention			
Repeated Grade			
Suspended			
Failed or is failing a grade or subject			
Received any special education services			

Please describe any current special education services (e.g. IEP, 504 Plan, resource room support):

Previous Evaluations and Treatments (please bring copies of any reports)

Testing (such as educational, emotional, speech/language)

Date	Type of Testing	Where was the testing done? (e.g. School, Private Psychologist, etc)

Outpatient Mental Health Professionals Seen:

Professional's Name/Specialty (e.g. psychiatrist, psychologist, social worker, school counselor)	Start Date	End Date	Type of services received

What do school personnel tell you about your child? _____

Your Child's Education (cont.)

Grade	School	Average Grade	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Your Child's Family

Member	Name	Age/Grade	Describe child's relationship with member
Father			
Mother			
Sister(s)			
Brother(s)			
StepFather			
StepMother			
StepSister(s)			
StepBrother(s)			

List other people who live in the home with this child:

Your Child's Routine

What kinds of physical exercise does your child get? _____

How much coffee, cola, tea, or other caffeine does your child consume each day _____

Is your child's eating restricted in any way? How? Why? _____

Bedtime: _____ Wake-up Time: _____ Hours of sleep on an average night: _____

Does your child have any problems getting enough sleep? ____ If yes, please describe: _____

Your Child's Health

Who is your child's pediatrician? _____ When was the last visit? _____

Any concerns shared by the doctor? _____

Anything else you are concerned about? _____

(These questions are regarding older children)

Is this child in a gang? ____ Has this child used drugs? _____. If so, describe which drugs, frequency, age at first use, and amounts _____

Has this child ever been pregnant or fathered a child? ____ If yes, please tell what happened _____

Your Child's Health (cont.)

Is there any history of physical or sexual abuse?

Child Protective Services Report? _____

If your child has taken medication for attention, behavior, or emotional problems, please list:

Medication	Dosage (e.g. 20 mg 3x day)	Start	End	Prescribed By	Adverse Effects

Please List ANY Drug or Food

Allergies _____

If your child takes any other medication or supplements for any other reason, please list:

Psychiatric Hospitalization or Inpatient Drug Treatment

Place	Date Started	Date Stopped	Reason for admission

Has your child or family received services or case management through an agency (e.g. Child Protective Services, Department of Mental Health and Mental Retardation, etc.)?

Agency: _____

Service: _____

Agency: _____

Service: _____

Your Child's Developmental History

Pregnancy and Delivery

Age of mother at birth: ____ yrs

Medications taken during pregnancy: _____

Gestational diabetes? Yes No

Problems with blood pressure or toxemia? Yes No

Infections (including herpes) _____

Smoking (if so, how many packs per day) _____

Alcohol _____

Drugs taken _____

Any problems during labor or delivery: _____

Duration of pregnancy: _____ weeks

Type of labor: _____

Birth weight: _____

Any problems after birth: _____

Infancy/Toddler

Describe your child as an infant and toddler: _____

Problems with feeding Y N

Severe colic or excessive crying Y N

Irritable Y N

Overactive Y N

Easily overstimulated Y N

Withdrawn Y N

Didn't like to be held Y N

Difficult to soothe Y N

Developmental Milestones:

Indicate the age at which your child achieved the following:

Sit up _____

Crawl _____

Walk without assistance _____

Speak in 2 word sentences _____

Toilet trained during the day _____

Dry at night _____

Your Child's Medical History

Medical History

Major Illness	Date	Hospitalized?	Surgery?

Has your child ever had a head injury with loss of consciousness? If yes, please describe:

Has your child ever had a seizure? If yes, please describe:

Family History

Does anyone in the child's biological family have:	No	Yes	Relationship to child
Attention problems/ADHD			
Behavior problems in youth			
Learning Disability			
Seizures			
Mental Retardation			
Tics/Tourette's Syndrome			
Autistic spectrum disorder			
Thyroid Problems			
Heart Problems before age 50			
Depression			
Bipolar Disorder			
Anxiety or Panic Attacks			
Obsessive Compulsive Disorder			
Schizophrenia			
Alcohol Problems			
Drug Problems			
Trouble with the law			

Any other significant family medical or psychiatric history _____

Your Child's Symptoms

<input type="checkbox"/> Accident-prone <input type="checkbox"/> Affectionate <input type="checkbox"/> Aggressive <input type="checkbox"/> Argues <input type="checkbox"/> Assaults <input type="checkbox"/> Bathroom language <input type="checkbox"/> Bigoted <input type="checkbox"/> Bossy to others <input type="checkbox"/> Breaks rules <input type="checkbox"/> Breaks the law <input type="checkbox"/> Bullied by others <input type="checkbox"/> Bullies others <input type="checkbox"/> Cheats <input type="checkbox"/> Clowns around <input type="checkbox"/> Competition <input type="checkbox"/> Complains <input type="checkbox"/> Complains of feeling sick <input type="checkbox"/> Compliant <input type="checkbox"/> Concern for others <input type="checkbox"/> Conflicts at school <input type="checkbox"/> Conflicts at home <input type="checkbox"/> Conflicts with friends <input type="checkbox"/> Conflicts with police <input type="checkbox"/> Cries easily <input type="checkbox"/> Cruel to animals <input type="checkbox"/> Dares others <input type="checkbox"/> Dawdles <input type="checkbox"/> Daydreams <input type="checkbox"/> Defiant <input type="checkbox"/> Dependent <input type="checkbox"/> Destructive <input type="checkbox"/> Developmental delays <input type="checkbox"/> Difficulty w parent's partner <input type="checkbox"/> Disobedient <input type="checkbox"/> Disrupts family activities <input type="checkbox"/> Distractible <input type="checkbox"/> Dropping out of school <input type="checkbox"/> Drug or alcohol use <input type="checkbox"/> Drug sales <input type="checkbox"/> Eating Issues <input type="checkbox"/> Failure in school <input type="checkbox"/> Fantasy life <input type="checkbox"/> Fearful <input type="checkbox"/> Feelings are easily hurt <input type="checkbox"/> Fidgety <input type="checkbox"/> Fighting <input type="checkbox"/> Finger sucking <input type="checkbox"/> Fire setting <input type="checkbox"/> Friendly <input type="checkbox"/> Hair chewing <input type="checkbox"/> Head banging <input type="checkbox"/> Hitting <input type="checkbox"/> Hostile	<input type="checkbox"/> Hyperactive <input type="checkbox"/> Hypochondriac <input type="checkbox"/> Imaginary playmates <input type="checkbox"/> Immature <input type="checkbox"/> Inappro. sexual behaviors <input type="checkbox"/> Inattentive <input type="checkbox"/> Independent <input type="checkbox"/> Inflicts pain on others <input type="checkbox"/> Insults others <input type="checkbox"/> Interrupts <input type="checkbox"/> Intimidated by others <input type="checkbox"/> Intimidates others <input type="checkbox"/> Intolerant <input type="checkbox"/> Irritability <input type="checkbox"/> Isolates <input type="checkbox"/> Lacks organization <input type="checkbox"/> Lacks respect for authority <input type="checkbox"/> Learning disability <input type="checkbox"/> Legal difficulties <input type="checkbox"/> Lethargic <input type="checkbox"/> Likes to be alone <input type="checkbox"/> Loitering <input type="checkbox"/> Loss of friends <input type="checkbox"/> Low frustration tolerance <input type="checkbox"/> Lying <input type="checkbox"/> Manipulates <input type="checkbox"/> Masturbation <input type="checkbox"/> Mental retardation <input type="checkbox"/> Moody <input type="checkbox"/> Mute, refuses to speak <input type="checkbox"/> Nail biting <input type="checkbox"/> Name calling <input type="checkbox"/> Needs constant supervision <input type="checkbox"/> Negativism <input type="checkbox"/> Nervous <input type="checkbox"/> New school <input type="checkbox"/> Nightmares <input type="checkbox"/> Noisy <input type="checkbox"/> Noncompliant <input type="checkbox"/> Obedient <input type="checkbox"/> Obesity <input type="checkbox"/> Only younger playmates <input type="checkbox"/> Oppositional <input type="checkbox"/> Outgoing <input type="checkbox"/> Out-of-seat behaviors <input type="checkbox"/> Overactive <input type="checkbox"/> Picks on others <input type="checkbox"/> Poor concentration <input type="checkbox"/> Pouts <input type="checkbox"/> Prejudiced <input type="checkbox"/> Procrastinates <input type="checkbox"/> Provokes others <input type="checkbox"/> Rages	<input type="checkbox"/> Recent move <input type="checkbox"/> Refuses <input type="checkbox"/> Relationships with friends <input type="checkbox"/> Relationships with siblings <input type="checkbox"/> Relationships with teachers <input type="checkbox"/> Repetitive movements <input type="checkbox"/> Resists <input type="checkbox"/> Responsible <input type="checkbox"/> Restless <input type="checkbox"/> Runs away <input type="checkbox"/> Sad <input type="checkbox"/> School avoiding <input type="checkbox"/> Self-harming behaviors <input type="checkbox"/> Sexual preoccupation <input type="checkbox"/> Sexually active <input type="checkbox"/> Shy <input type="checkbox"/> Slow-moving <input type="checkbox"/> Slow-responding <input type="checkbox"/> Smart-alecky <input type="checkbox"/> Smoking <input type="checkbox"/> Social <input type="checkbox"/> Speech difficulties <input type="checkbox"/> Stealing <input type="checkbox"/> Stubborn <input type="checkbox"/> Suicide talk or attempt <input type="checkbox"/> Swearing <input type="checkbox"/> Talks back <input type="checkbox"/> Talks out <input type="checkbox"/> Teased <input type="checkbox"/> Teases others <input type="checkbox"/> Temper tantrums <input type="checkbox"/> Threatens <input type="checkbox"/> Thumb sucking <input type="checkbox"/> Tics-movements or noises <input type="checkbox"/> Timid <input type="checkbox"/> Truancy <input type="checkbox"/> Uncooperative <input type="checkbox"/> Uncoordinated <input type="checkbox"/> Underactive <input type="checkbox"/> Unhappy <input type="checkbox"/> Unprepared <input type="checkbox"/> Vandalism <input type="checkbox"/> Violent <input type="checkbox"/> Wastes time <input type="checkbox"/> Wetting/soiling bed/clothes <input type="checkbox"/> Withdraws <input type="checkbox"/> Work problems <input type="checkbox"/> Yells <input type="checkbox"/> Any other characteristics:
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About Cambridge Nichols, LPC, NCC

Please initial each line to indicate that you understand each statement.

- ☐ I understand that Cambridge Nichols is a Licensed Professional Counselor
- ☐ I understand that Cambridge Nichols works with children, adolescents, and adults in individual, group, and family counseling.
- ☐ I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.
- ☐ I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.
- ☐ I understand that if I am concerned about slow progress or lack of progress I have the right to speak to Cambridge Nichols about this.
- ☐ I understand that Cambridge Nichols does not perform formal testing but refers to those who do.
- ☐ I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.
- ☐ I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct Cambridge Nichols to tell someone else in writing or verbally, b) Cambridge Nichols determines that his client poses a threat to them self or others, c) he is ordered by a court to disclose information, or d) He suspects that child abuse has taken place, at which time he will notify Child Protective Services.
- ☐ I understand that counseling can improve as well as upset the equilibrium in any person or family.
- ☐ I understand that I cannot resolve a complaint with Cambridge Nichols and wish to file a formal complaint, I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.
- ☐ I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to Cambridge Nichols.
- ☐ I understand that there is a returned check fee of \$25.00 and that if a returned check is not cleared up in 30 days, Cambridge Nichols will file a suit with the Travis County District Attorney's Office.
- ☐ I understand that all co-pays are due at the time of service.
- ☐ I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged the full fee that will be debited from my Visa or MasterCard.
- ☐ I understand that the rate for an initial session is \$100.00 and for subsequent sessions is \$70.00. These fees are for 30-minute sessions and \$90.00 for 45-minute sessions.
- ☐ I understand that Cambridge Nichols is not a psychiatrist. As such, she cannot recommend or prescribe medication, but can encourage clients to see an M.D. for evaluation.

By signing below I confirm that I have read, agree to, and understand the above information:

X _____
Signature of patient or parent/legal guardian if minor

X _____
Date of signature

Agreement for Therapy with a Minor

I, _____, the parent/legal guardian of the minor, _____,

☐ Give my permission for this minor to receive therapeutic services provided from Cambridge Nichols.

☐ I have read, understood, and signed the Professional Disclosure Statement of Cambridge Nichols and I understand the risks and benefits of receiving these services and the risks and benefits of *not* receiving these services, for both this minor and his or her family.

☐ Furthermore, I understand that I am expected to participate in this process by meeting with the therapist at least once per month while my child is in therapy.

My signature below means that I understand and agree with all of the points above.

X _____

Signature of patient or parent/legal guardian if minor

X _____

Date of signature

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by us.
2. Assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human Services. You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice. The Notice of Privacy Practices is effective as of April 14, 2003.

THIS IS YOUR COPY TO KEEP

Acknowledgement of Receiving Notice of Privacy Practices

I acknowledge that I have received and understand the Notice of Privacy Practices for this office:

X_____

Signature of patient or parent/legal guardian if minor

X_____

Date of signature

Consent for Use and Disclosure of Health Information

I hereby permit Cambridge Nichols, LPC, NCC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. X_____

X_____

Signature of patient or parent/legal guardian if minor

Date of signature

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

Please see our Notice of Privacy Practices for more complete description. You will find this Notice of Privacy Practices on a bulletin board in the hallway of our office suite. If this consent form is revised in the future, you may obtain a revised copy from this office.