Trailhead Counseling and Wellness, LLC
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Child/Adolescent Information/Consent Form

To be completed by parent/guardian

Welcome! Please fill out the following form as accurately and legibly as possible. This will help me to understand your child better and support us in developing goals for counseling.

Parent(s) Name(s): _____Today's Date: _____

Child's Legal Name: _____

Home Address: _____

City, State, Zip Code: _____

Phone #: (_____) _____ - _____ Home Cell Work

Child's Birthdate: _____Identified Gender: Male Female

Email Address: _____

Parent(s) Living Arrangement:

Alone	With Partner	With Partner & Kids	With Kids	With Family

Names and Ages of Other Children (if applicable):

If kids live at home part time or part time away from home, please describe arrangement:

Please describe what brings your child/adolescent to counseling at this time:

On a scale of 1-10, how much distress do you feel your child is experiencing today?

1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10

No distress Overwhelming Distress

What do you/your child hope to accomplish through counseling? *(if different, please list separately)*

What have you and your child done already to deal with what is impacting them?

Have you or your child had previous psychological counseling or psychiatric help?

- ❑ **YES**
- ❑ **NO**

If yes, when and where did you/your child receive counseling and what were the circumstances? *(Individual, family, group, issues addressed, etc.)*

List any medications and dosage your child is taking:

Please list any significant health problems that your child has been treated for or are currently being treated for:

What are your child's biggest strengths? What do they do for fun and to relax?

Does your child exercise? YES NO

How many times per week? _____ For how long? _____

Please describe your child's eating habits:

Interactions between client and therapist are confidential. Unless I have specific permission from you, I will not discuss the content of our session with any outside parties. There are four exceptions to confidentiality that Oregon State Law requires mental health professionals to report.

1. Incidences of child or elder abuse
2. Intent to complete suicide
3. Threats to do harm to self or others
4. Court Order

Because parents play a key role in their child's life, there may be times in which information will need to be shared. However, in order to develop a trusting and safe therapeutic relationship, confidentiality will be maintained whenever possible. Parents, please understand there will be information shared with me that cannot be shared back to you. The issue of confidentiality will be discussed more in detail at the intake session to ensure that all family members feel comfortable and confident moving ahead with counseling.

Additionally, in the event of a billing dispute, names, dates, and lengths will be disclosed to a collection agency and/or attorney.

The community we live in can often feel small and the possibility that we may see each other outside of therapy is always present. Your confidentiality is priority in these situations. I will leave it to you if you would like to verbally or nonverbally recognize our encounter. I will follow your lead as I understand that everyone has different comfort levels when it comes to the privacy of their therapy.

If I am not able to make an appointment, I will cancel the appointment by phone or email with at least 24-hour notice. If I miss a scheduled appointment without giving 24-hour notice, I agree to pay the full session of the fee.

$120 per 50 minute session for individual and/or child/adolescent.
$150 per 75 minute session for families.

**All fees are due at the time of service and can be paid by cash, check, or credit card *(Visa, Mastercard, Discover, American Express)*

My office is located at 780 NW York Drive, Suite 204. Suite 204 is a shared office space amongst multiple businesses. Please enter the door and have a seat in the open area between the offices. Please be respectful of other businesses while waiting for your appointment.

I have read and understand all aspects of this form and agree to the terms and conditions. By signing below, I am consenting to therapy and releasing Trailhead Counseling and Wellness, LLC/Andrew Krauthoefer, NCC, LSC, LPCi from any and all liability resulting from therapy. I am the party responsible for payment of services and will pay in full at the time of each therapy session. My signature below also confirms that I have received a copy of the "HIPAA Notice of Privacy Practices" and a "Professional Disclosure Statement" at the beginning of the first therapy session. I also understand I can view and download copies of both of the above at Andy's website: www.trailheadcw.com under the "forms" tab.

Printed Legal Name: _____

Signature: _____ **Date:** _____