



CHILD AND ADOLESCENT PATIENT INFORMATION SHEET

Full Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Ethnicity: _____

Address: _____

Parents' Names: _____

Parents' Marital Status: ☐Single ☐Engaged ☐Partnered ☐Married ☐Remarried ☐Cohabiting ☐Divorced ☐Separated ☐Widowed

Parent Phone: _____ Can we leave messages? ☐Yes ☐No

Parent Phone: _____ Can we leave messages? ☐Yes ☐No

Parent Email Address: _____ Can we leave messages? ☐Yes ☐No

Parent Email Address: _____ Can we leave messages? ☐Yes ☐No

Grade Level: _____ Grade Average: _____ School: _____

Are you receiving special services/accommodations at school? ☐Yes ☐No

If yes, please explain: _____

Extracurricular Activities: _____

In case of emergency who should I contact?

Name: _____ Relationship: _____ Phone: _____

Present state of health: ☐Excellent ☐Good ☐Fair ☐Poor

Primary Care Physician: _____ Psychiatrist: _____

Current Medical Problems: _____

Current Medications: _____

Describe any significant hospitalizations/accidents/surgeries: _____

History of treatment by a mental health professional? ☐Yes ☐No *If yes, answer the following:*

Outpatient therapy: ☐Yes ☐No Dates: _____

For what problem(s)? _____

Inpatient treatment: ☐Yes ☐No _____

Dates: _____

For what problem(s)? _____

Do you consider your child to be spiritual or religious? ☐Yes ☐No

If yes, describe their faith or belief: _____

Who gave you my name to call:

Name: _____ Phone: _____

May I thank the person that gave you my name? ☐Yes ☐No

Briefly describe your primary concern and/or symptoms.

How long has this been a major problem?

Did anything happen shortly before your identified problems occurred (loss, death, job change, separation, divorce, birth, adoption, medical diagnosis, relocation, etc.)? ☐Yes ☐No If *yes*, please explain:

Describe briefly the child’s family and current primary relationships:

Other areas of difficulty/concern.

What are their strengths? What is going well?

List any other factors/circumstances that may be relevant to treatment.

What are your goals for counseling?

SYMPTOM CHECKLIST

How often does your <i>child</i> experience concerns related to:	Never	Rarely	Sometimes	Often	Almost Always
Academic performance					
Argues, “talks back,” defiant					
Bullies/intimidates, teases, is bossy to others					
Cheats, lies					
Complains, pouts					
Cries easily, feelings are easily hurt, sensitive					
Cruel to animals					
Dawdles, procrastinates, wastes time					
Dependent, “needy,” trouble with separation					
Developmental delays					
Difficulties with parent’s new marriage/new family					
Difficulty falling/staying asleep					
Disobedient, uncooperative, doesn’t follow rules					
Disrupts family activities					
Poor concentration, daydreams, slow to respond					
Drug or alcohol use					
Compulsive overeating, restricting, bingeing, purging					
Poor manners, appetite increase or decrease					
Engages in rituals, strict routines					
Fearful, scares easily					
Fighting, violent, aggressive, hostile, destructive					
Immature, “clowns around,” only has younger friends					
Interrupts, talks out, yells					
Lacks organization, unprepared					
Lacks respect for authority, insults, provokes, manipulates					
Learning disability					
Likes to be alone, withdraws, isolates					
Low frustration tolerance, irritability					
Mental slowness					
Moody					
Mute, refuses to speak					
Nail biting					
Need for high degree of supervision over schedule/chores/play					
Nervous, worried, anxious					
Nightmares, night terrors, sleep walking					
Obesity					
Obsessions, compulsions					
Overactive, restless, hyperactive					
Picking at skin, acne, scabs					
Pulling out hair					
Recent move, new school, loss of friends					
Rocking or other repetitive motions					

How often does your <i>child</i> experience concerns related to:	Never	Rarely	Sometimes	Often	Almost Always
Runs away, elopes					
Sad, unhappy					
Self harming behaviors					
Public masturbation, inappropriate behaviors					
Shy, timid, socially nervous					
Speech difficulties, stutters					
Stubborn, willful					
Suicide talk or attempt					
Swearing, cussing, foul language					
Teased, picked on, bullied					
Temper tantrums					
Tics, involuntary movements, noises or word productions					
Truant, school refusal, school phobic					
Uncoordinated, accident-prone					
Wetting or soiling the bed or clothes					
Worries about health, complaints of being sick					

DISABILITY INVOLVEMENT INFORMATION

Have you applied or are you in the process of applying for disability benefits for your child? ☐ Yes ☐ No

If no, are you considering applying for disability benefits in the future? ☐ Yes ☐ No

If yes, please explain: _____

LEGAL INVOLVEMENT INFORMATION

Have you applied or are you in the process of applying for disability benefits? ☐ Yes ☐ No

If *no*, are you considering applying for disability benefits in the future? ☐ Yes ☐ No

Have you applied or are you in the process of applying for workman's compensation? ☐ Yes ☐ No

If *no*, are you considering applying for workman's compensation in the future? ☐ Yes ☐ No

Are you currently in any legal proceedings? ☐ Yes ☐ No

If *yes*, please explain: _____



CHILD/ADOLESCENT PSYCHOTHERAPY FEE AGREEMENT

Chris Mayo, LCSW

Service:	Fee:
Initial Psychotherapy Evaluation (Intake)	\$205
Individual Psychotherapy	\$185
Letter Writing/Form Completion	\$75 per half hour
Phone Calls <i>*This service is used only in rare circumstances and refers to phone conversations outside of session, initiated by the client with the therapist, either directly or on the client's behalf.</i>	\$75 per 15 minutes, billed at 15-minute increments
Late Cancellations of Appointments <i>*Please Note: Cancellations made less than 24 business hours before scheduled appointment time will incur the FULL session fee (not reimbursable by insurance). For example: a 10:00 a.m. Monday appointment must be canceled by 10:00 a.m. Friday.</i>	\$185

By signing below, I agree to the above fee structure.

Patient Printed Name

Parent/Guardian Printed Name

Patient Signature

Date

Parent/Guardian Signature

Date



CONSENT TO TREATMENT

I acknowledge I have *received*, have *read* (or have had read to me), and *understand* the **Therapist-Client Services Agreement**, and other information about the therapy I am considering. I have had all my questions answered fully.

I acknowledge I have *received*, have *read* (or have had read to me), and *understand* the **Notice of Privacy Practices**. I have had all my questions answered fully.

I consent to treatment by the therapist named below (or consent to treatment for my child) and agree to participate actively in the therapeutic process. I understand that no guarantees have been made regarding the results of treatment.

I may discontinue treatment at any time but remain responsible for payment of services already provided.

I have read the appointment information and understand that appointments must be canceled or rescheduled at least 24 business hours in advance. Cancellations made with less notice, or missed appointments, will be charged the full session fee, which is not reimbursable by insurance.

I agree to the terms in the Billing and Insurance Information section and understand that, if I use insurance, information about my services may be shared with my insurance company or other third-party payer as necessary for billing and payment. I understand that treatment may be discontinued if payment is not made, and referrals to other qualified providers may be offered.

My signature below shows that I understand and agree with all of these statements.

Patient Printed Name

Parent/Guardian Printed Name

Patient Signature

Date

Parent/Guardian Signature

Date

I, the therapist, have discussed the issues above with the patient (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Chris Mayo, LCSW

Therapist Printed Name

Therapist Signature

Date



STATEMENT OF MEDICAL DECISION MAKING FOR A MINOR

Client Name: _____ Client Date of Birth: _____

I, _____, state and attest that I may legally consent to mental health and/or substance abuse treatment for the above listed minor child under the following authority:

- ☐ Biological Parent
- ☐ Adoptive Parent
- ☐ Department of Human Services representative – Department has custody of child and authority to consent to treatment.
- ☐ Other Legal Guardian – Legal guardian appointed by the court to have medical decision-making authority.
- ☐ Delegated Authority – A parent or legal guardian of minor child has, by power of attorney, delegated the medical decision-making authority for a period of up to twelve months.
- ☐ Other – Please explain: _____

Divorce or Other Legal Proceedings

Have there been any legal proceedings or actions that have affected the decision-making authority regarding the minor child, including but not limited to: a divorce proceeding, a legal separation proceeding, a paternity proceeding, a termination or limitation of parental rights, or an assignment of legal custody/guardianship?

- ☐ Yes ☐ No

If yes, please explain. _____

If there is a court order or stipulated parenting agreement, which parent has medical decision-making authority for the minor child:

- ☐ Father has sole medical decision-making authority
- ☐ Mother has sole medical decision-making authority
- ☐ Both parents share medical decision-making authority
- ☐ Other – Please explain: _____

Please note: The person signing this statement should provide legal documentation verifying legal authority to make medical decisions for the minor child, unless the person signing is the biological or adoptive parent and there have been no legal proceedings or actions that have affected their decision-making authority regarding the minor child.

Patient Printed Name

Parent/Guardian Printed Name

Patient Signature

Date

Parent/Guardian Signature

Date



APPOINTMENT AVAILABILITY

Client Name: _____ Therapist Name: _____

This form helps us understand your scheduling needs so we can arrange appointments accordingly. Our office hours are Monday through Thursday, with both morning and evening appointments available. Late afternoon and evening appointments are in highest demand and may be limited. We will do our best to match your availability with the next available appointment and appreciate your flexibility when adjustments are needed.

Please cross out the times you are **UNAVAILABLE** and **CANNOT** make appointments.

	Monday	Tuesday	Wednesday	Thursday
8:30am				
9:30am				
10:30am				
11:30am				
12:30pm				
1:30pm				
2:30pm				
3:30pm				
4:30pm				
5:30pm				
6:30pm				

Does your schedule change frequently (i.e. weekly work schedule)?

Are there any potential changes in your schedule in the near future (i.e. changing school schedules)?

Is there any other additional information that would help us in scheduling your appointments?



COMMUNICATION AUTHORIZATION

During treatment, you may communicate with our office by email or other electronic methods. Please be aware that these communications are not completely secure and may be accessed by others, including individuals with access to your devices, your employer (if using work systems), or third parties involved in internet transmission.

If you are concerned about confidentiality, please discuss secure communication options with your therapist.

Please note that appointment reminders may be sent by email, phone, or text. Do not reply directly to these automated messages, as responses are *not* monitored. For questions or appointment changes, please contact our office directly.

Georgia Center for OCD & Anxiety may contact me using the following methods:

Email: _____

Ok to send encrypted emails? ☐ Yes ☐ No

Ok to send *unencrypted* emails? ☐ Yes ☐ No

Would you like automated email appointment reminders? ☐ Yes ☐ No

**Please note: If you prefer to communicate via unencrypted email, there may be some level of risk that the information contained in the email could be read by a third party.*

Phone: _____

Ok to leave messages? ☐ Yes ☐ No

Would you like automated phone call appointment reminders? ☐ Yes ☐ No

Text Messages:

Ok to send texts? ☐ Yes ☐ No

Would you like automated text appointment reminders? ☐ Yes ☐ No

Preferred Mailing Address: _____

Would you like correspondence mailed in an unmarked envelope? ☐ Yes ☐ No

I understand the risks of electronic communication, including potential confidentiality risks when transmitting protected health information through unsecured methods. I have read and understand the Notice of Privacy Practices. I understand that signing this agreement is not required to receive treatment and that I may revoke or update my contact preferences at any time.

Patient Printed Name

Parent/Guardian Printed Name

Patient Signature

Date

Parent/Guardian Signature

Date