



MY HEALING PLACE
Child/Adolescent
Registration & Information Form

DB
Group:
Therapist:
Termination:

Date _____

Name of Child/adolescent _____ Birth Date of Child _____

Name of person completing this form _____

Relationship to child/adolescent _____

Daytime Contact # _ (____) _____ Alternate Phone # _ (____) _____

Mailing Address _____
ADDRESS CITY ZIP

Email _____

Place of Work _____ Work Phone _ (____) _____

Occupation _____

Emergency Contact Person _____

Emergency Contact Phone # _ (____) _____

School currently enrolled in: _____ Grade: _____

School District _____

List the persons currently living with the child/adolescent. Include their names and relationship to the child/adolescent.

What brings the child/adolescent to therapy at this particular time? *(if additional space is needed please feel free to write on the back side of this form)*

What would you like the child/adolescent to gain through participation in grief/trauma therapy at this time?

Is the loss a death loss? ____ (Y/N) Date of the loss: _____
If yes, briefly describe the child's/adolescent's relationship to the deceased.

Is the loss a non-death loss? *(Circle one or more.)*

Divorce Separation Abuse Incarceration Deployment Assault Abandonment
Other _____

Date that this loss occurred: _____

Please describe the circumstances of the loss that brings you to My Healing Place. If this is a death loss, please describe the cause of death and any other important details.

How did your child/adolescent find out about the loss?

If possible, write down the words used to explain the loss to your child/adolescent.

If this is a death loss, in what aspects of the rituals following the death did your child/adolescent participate? (i.e. visitation, funeral, etc.)

What questions or comments has your child/adolescent made about this loss?

Please list any other significant losses (death and non-death) your child/adolescent has experienced. (e.g.: pet death, divorce, geographic moves, significant change in parent work status or socioeconomic status, removed from sports team, etc.)

Who are the people / groups who support your child/adolescent?

Please place a check mark beside any of the following you have observed about your child/adolescent:

- | | | |
|---|--|--|
| <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> heightened levels of irritation | <input type="checkbox"/> anger outbursts |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> high levels of anxiety | <input type="checkbox"/> stomachaches |
| <input type="checkbox"/> easily frustrated | <input type="checkbox"/> changes in appetite | <input type="checkbox"/> headaches |
| <input type="checkbox"/> inability to concentrate | <input type="checkbox"/> easily startled | <input type="checkbox"/> withdrawn |
| <input type="checkbox"/> difficulty getting up in the morning | <input type="checkbox"/> frequent crying | <input type="checkbox"/> clinginess |
| <input type="checkbox"/> thoughts of hurting self | <input type="checkbox"/> fatigue | |

Is the child/adolescent in any other form of therapy at this time? _____ (Y/N)
If yes, please provide the name and contact information of the therapist.

_____ THERAPIST'S NAME _____ PHONE NUMBER

Has the child/adolescent ever participated in counseling or therapy in the past? ____ (Y/N)
If yes, briefly describe the reasons for seeking help and the outcome of the therapy.

Is the child/adolescent currently under the care of a physician? ____ (Y/N)
If yes, please give us the name and phone number of the physician.

DOCTOR'S NAME

DOCTOR'S PHONE NUMBER

Please list any prescription medications the child/adolescent is currently taking.

Please list any significant food allergies your child/adolescent has. (Some of our children's groups offer "snack time").

Please tell us anything else that may be helpful for us to know about your child/adolescent and your situation as he/she participates in grief therapy at My Healing Place.

How did you find out about My Healing Place?



MY HEALING PLACE
Consent for Treatment
Child/Adolescent Services

I, _____, hereby give full consent for my child, _____ to receive the services of My Healing Place until I give notification of any changes or until My Healing Place determines that services are no longer necessary, I certify that I have legal responsibility for this child and am authorized to seek treatment for him/her. I understand that if any court reports, court appearances or court consultations are required in association with treatment at My Healing Place, I will be responsible for payment in advance at full fee for these services. I agree to give My Healing Place advance notice of such services. In addition, I understand that as a client of My Healing Place my child and I have the following rights and responsibilities in the therapeutic setting:

- To be treated with dignity and respect.
- To appropriate treatment in the least restrictive setting available consistent with the protection of myself and others
- To give input for my own treatment plans.
- To an explanation of the benefits, effects, alternatives and risks of all treatment.
- To refuse treatment and receive an explanation of possible consequences of refusing, unless the court orders such.
- To meet with the person treating me, and to an explanation of their qualifications, title, and responsibilities.
- To request at my own expense, the opinion of a consultant to review my treatment.
- To my records being kept in a confidential manner. Though they are the property of My Healing Place, I may request access to them by following the policies and procedures for such requests.
- To be free from abuse, neglect, and exploitation.
- To be treated without discrimination.
- To make a complaint about my treatment and rights without such complaints being used against me.
- To be honest, open and willing to share my concerns with my counselor.
- To ask questions when I do not understand or need clarification.
- To report changes or unexpected events as related to my problems with my therapist.

Normal sessions are 50 minutes in length. Payment for each session is due at the time of the visit. You will be charged for all scheduled appointments unless cancellation notice is received AT LEAST 24 HOURS PRIOR to the appointment time so that the time may be rescheduled.

My child's records and/or any information conveyed by myself and/or members of my family to personnel at My Healing Place will not be released without my written permission unless required by Texas law. (Reporting alleged or suspected incidents of child or elderly abuse, suicidal ideation or gestures, sexual exploitation by a therapist or threats of harm to self or others is mandatory under the Texas Family Code.)

Signature of Parent/Guardian/Managing Conservator

Date

Signature of Therapist/Witness

Date

Limits of Confidentiality

Information discussing the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under 18) and reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a therapist.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and /or agencies.

Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of this state.

Having read and understood the above, I agree to these limits of confidentiality.

Client signature (or guardian if under 18)

Date

Name of Client (or guardian if under 18)

Signature of MHP Therapist