



Tiffany Adams, LCSW
1348 West State Road, Suite 104
Pleasant Grove, Utah 84062
(801)691-2711
tiffcsw@intheplayroom.com
www.intheplayroom.com

CONSENT FOR TREATMENT OF A MINOR CHILD

(The following statements provide your legal consent to and financial responsibility for counseling services to a minor child. These statements are important to protect the child, the parent/guardian/conservator, and the therapist. Please carefully review this information and sign where indicated. You are requested to discuss any question you may have with the therapist.)

STATEMENT OF RESPONSIBILITY AND GRANT OF PERMISSION FOR THERAPY

I am the : Natural Parent: [] Legal Guardian: [] Managing Conservator of []

(Name of minor child)

I am legally responsible for the child named above and grant permission to Tiffany Adams, LCSW to conduct therapy with this child.

I accept responsibility for the timely payment of all fees due to Tiffany Adams, LCSW for services provided to this child.

Signature: _____ Date: _____

DUTY TO WARN NOTICE

Tiffany Adams, LCSW, is committed to the confidentiality and privileged communication with all clients. There are, however, several exceptions. According to Utah law, any evidence of child abuse must be reported to the authorities. If any individual intends to take harmful, dangerous, or criminal action against another individual, or against himself/herself, it may be the therapist's duty to report such action or intent.

Signature: _____ Date: _____



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Child-Adolescent Intake

Please provide the following information about your child:

Child's Full Name:	Nickname:
Birth Date:	Today's Date
Child's Address:	Phone:
Parent(s) names or primary guardian:	Parent(s) contact numbers: Home: Cell: Work
In case of emergency, who may I contact on your behalf?	Name:
Phone number:	Relationship:

Education History

What school does your child attend:	Teacher's Name:
Current Grade:	Has your child ever repeated a grade? YES/ NO If so which one(s)_____
Favorite Subject:	Least Favorite Subject:
Does child receive special education service? YES /NO	Does child receive tutoring? YES/ NO
Is your child in a gifted/talented/honors program? YES/ NO	Does child like school? YES/ NO
Has you child experienced any of the following at school? (please circle all that apply) Fighting, suspension, lack of friends, gang influence, learning disabilities, incomplete homework, dug/alcohol, poor attendance, behavior problems, detention ,poor grades	
Has your child been the victim of bullying or bullied other children? YES/ NO. If yes, please describe	
Please, use the space to provide any other additional information regarding your child's education or developmental history that you find significant:	



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Medical History

Pediatrician's Name:	Phone:
Is child under the care of another medical specialist? YES/NO. If yes, type of specialist _____	Phone:

Please list any chronic illness, disabilities, medical conditions that your child has been diagnosed with:

Illness/Disability	Dates

List all medications that your child is currently taking:

Medication	Dosage	Treating

Therapy / Psychiatric Experience

Is your child <i>currently</i> seeing another therapist? YES / NO			
If yes, who are you seeing?			
Has your child ever been in therapy in the past YES/ NO			
If yes, please fill out the following on your previous counseling experience(s)			
Therapist	Location	Dates	Reason
Has your child ever had a psychiatric hospitalization? YES/ NO			
If yes describe briefly and indicate dates and circumstances			



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Is your child under the care of a psychiatrist: YES/ NO	If yes, Psychiatrist name:
Phone:	Address:

Other History

Has your child ever experienced any type of abuse (physical, sexual, or emotional)? YES/ NO If yes, please describe:
Has your child ever made statement of wanting to harm him/herself or seriously hurt someone else? YES/ NO Has he/she purposely hurt himself or another? YES/ NO If yes, to either question please describe the situation:
Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? YES/ NO. If yes, please explain:
Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets him/her in trouble? YES/NO. If yes, please describe:
Are there any behaviors that your child fails to do as often as you would like or when you would like?
Please list positive strengths of your child: (What do you like about your child? What do others like about your child?)
How would you describe your child's self-esteem?
Briefly describe your reason(s) for seeking help at this time?



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Are child's parents'? Married Separated Divorced Widowed (please circle one)
If parents divorced/separated please list dates:
Who in the family is your child closest too?
What are some of the strengths of your family?
Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? YES / NO If yes please describe:
Does anyone in the child's family been diagnosed with a chronic/mental illness? YES/ NO. If yes, please describe:
Is there anything else that you think would be important for me to know about your child, you, or your family?
How did you hear about our services? Internet search? Website?