Tiffany McPherson, LCSW
1550 South Midway Ave.
Idaho Falls, ID 83406

(208)709-3164
tifflcsw@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 McPherson, LCSW to conduct therapy with this child.

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

Signature: ___________________________________ Date: __________________

DUTY TO WARN NOTICE

Tiffany McPherson, LCSW, is committed to the confidentiality and privileged communication with all clients. There are, however, several exceptions. According to Idaho 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: ________________

Tiffany McPherson, LCSW
1550 South Midway Ave.
Idaho Falls, ID 83406

(208)709-3164
tifflcsw@intheplayroom.com
www.intheplayroom.com

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 vitamin 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:	

Tiffany McPherson, LCSW
1550 South Midway Ave.
Idaho Falls, ID 83406

(208)709-3164
tifflcsw@intheplayroom.com
www.intheplayroom.com

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 *currently* 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			

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

Tiffany McPherson, LCSW
1550 South Midway Ave.
Idaho Falls, ID 83406

(208)709-3164
tifflcsw@intheplayroom.com
www.intheplayroom.com

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 him/her self 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?
What goals do you wish to accomplish during the therapy process as a parent?

Tiffany McPherson, LCSW
1550 South Midway Ave.
Idaho Falls, ID 83406

(208)709-3164
tifflcsw@intheplayroom.com
www.intheplayroom.com

What goals does your child wish to accomplish during the therapy process? (can be different than parent's response)

Family History

Mother's Name Occupation:		Father's Name: Occupation:	
Step-Mother?		Step Father?	
Who does your child currently live with?			
Names	Age	Relationship to child	Grade/Job
Who are your child's significant others NOT living with your child?			
Names	Age	Relationship to child	Grade/Job
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?			

Tiffany McPherson, LCSW
1550 South Midway Ave.
Idaho Falls, ID 83406

(208)709-3164
tifflcsw@intheplayroom.com
www.intheplayroom.com

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?

Tiffany McPherson, LCSW
1550 South Midway Ave.
Idaho Falls, ID 83406

(208)709-3164
tifflcsw@intheplayroom.com
www.intheplayroom.com

Scope of Practice

I am informed and understand that Tiffany McPherson is a licensed independent professional who addresses mental health issues and related symptoms. In this role, Ms. McPherson will operate within her scope of practice and provide clinical outpatient psychotherapy services. These services are intended to address my child's treatment and clinical needs and are not intended to serve in any other manner including those described below. As a part of treatment, recommendations regarding family system issues and/or other psychosocial matters which are impacting my child may occur. I understand that consideration of these recommendations will be a vital part of the therapy process. Failure to consider clinical recommendations and implement therapeutic changes may create substantial obstacles to my child's treatment and limit my child's ability to benefit from the outpatient psychotherapy services being provided.

I understand services provided by Tiffany McPherson, LCSW do not include placement or custody recommendations or decisions.

Initials _____

I understand services provided by Tiffany McPherson, LCSW do not include conducting a home study.

Initials _____

I understand services provided by Tiffany McPherson, LCSW do not include attachment studies.

Initials _____

I understand services provided by Tiffany McPherson, LCSW do not include making recommendations regarding whether or not a parent is a fit, competent, or capable parent.

Initials _____

I understand services provided by Tiffany McPherson, LCSW are not forensic in nature and do not include determining with exactness if something has or has not happened to my child.

Initials _____

With my signature below and in accordance with my initials above, I am giving informed consent in regard to the psychotherapy services provided to my minor child. I have had an opportunity to ask questions regarding Ms. McPherson's scope of practice and to address any concerns.

____ ____________
Minor Child's Name DOB

____ ____________
Parent/Guardian Signature Date

____ ____________
Tiffany McPherson, LCSW Date