Therapist:
Date:
Diagnosis:

2356 University Ave W, Suite 280
Saint Paul, MN 55114
651-646-1488 phone
651-646-2285 fax

Family Circle Counseling

Client Insurance Information and Financial Agreement

Client Name:	Date of Birth:
Responsible Party Name:	Relationship to Client:
Address:	Email:
Phone - Home: OK to leave message Y/N	Work: OK to leave message Y/N Cell: OK to leave message Y/N

IMPORTANT: It is essential that you fill out the rest of the form very carefully with **all the necessary information regarding ALL of your insurances**. If you do not give us accurate information you will then be responsible for payment, or will be charged for re-submission of claims.
I HAVE ONLY ONE INSURANCE and understand that if I have another one at any time and do not communicate the information to FCC, I might be responsible for payment in full. ❑Yes ❑No (If No, make sure you fill in all the information in the form below)

Insurance - Primary ID-Number:	Group Number:
Insurance Company Name:	Phone Number:
Insurance Claim Address:	
We get insurance through **MEDICARE**, the **Military**, or employment with a **Federal Government Agency** ❑ Yes ❑ No	
Name of Policy Holder:	Relationship to client:
Address (if different from above):	
Policy Holder's/Insurance Parent's ID Number:	Social Security No:
Date of Birth:	
If insurance is through employer, Employer Name:	
Employer's Address:	
Co-Pay:	**Deductible:**
Pre-authorization required: ❑ No ❑ Yes If Yes, number to call:	
Important: To bill your insurance,we must have a copy of your insurance card on file.	
Other Insurances - ID-Number:	Group Number:
Insurance Company Name:	Phone Number:
Insurance Claim Address:	
Name of Policy Holder:	Relationship to client:
Address (if different from above):	
Policy Holder's Social Security Number:	
Date of Birth:	
If insurance is through employer, Employer Name:	
Employer's Address:	
Co-Pay:	**Deductible:**
Pre-authorization required: ❑ No ❑ Yes If Yes, number to call:	

Children's Mental Health

Child/Adolescent Diagnostic Assessment

(TO BE COMPLETED BY PARENT/CAREGIVER)

PART 1 – Please provide the following information in preparation for the interview with your mental health clinician.

DATE

CHILD NAME (FIRST, MI, LAST)	CLIENT NUMBER	REFERRAL SOURCE

REASON FOR REFERRAL

NAME OF INDIVIDUAL COMPLETING FORM	RELATIONSHIP TO CHILD

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0001 (3-13)

ADA1 (12-12)

This information is available in accessible formats for individuals with disabilities by calling 651-431-2321, toll-free 800-627-3529, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

Living situation

Parent's Home	Residential Care/Treatment Facility**	Other**
☐ RENT ☐ OWN	☐ HOSPITAL ☐ TEMPORARY HOUSING ☐ RESIDENTIAL CARE ☐ NURSING HOME	☐ FRIEND'S HOME ☐ RELATIVE/GUARDIAN'S HOME ☐ HOMELESS ☐ FOSTER HOME

**IDENTIFY PERSON'S NAME OR FACILITY

Primary Household

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship

STREET ADDRESS (If different from child's address listed on Demographic Information form.)

Does the client live in more than one household?

☐ **NO** If no, skip to "Additional Family Members" ☐ **YES** If yes, complete the secondary household information below.

Secondary Household

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship

STREET ADDRESS (If different from child's address listed on Demographic Information form.)

Family members who live in both households

☐ ONLY CHILD

☐ CHILD and (list):

Additional family members

☐ NO, parents or sibling other than those listed in primary or secondary households

☐ YES, list family members:

Custody and parenting plan

☐ LIVES WITH BOTH PARENTS (biological or adoptive) in same household

☐ SINGLE PARENT

☐ SHARED CUSTODY – parents in different households

☐ OTHER (describe):

Developmental issues

Have you ever had concerns about the following issues with this child?

Pregnancy	Yes	No	Unknown
Had bleeding during first three (3) months	☐	☐	☐
Had bleeding during second three (3) months	☐	☐	☐
Had bleeding during last three (3) months	☐	☐	☐
Had toxemia	☐	☐	☐
Had to take medications Specify any medication: _____	☐	☐	☐
Got injured or hurt	☐	☐	☐
Gained less than 15 lbs. (7 kgs.) Specify: _____	☐	☐	☐
Took narcotic drugs	☐	☐	☐
Drank alcohol	☐	☐	☐
Had an infection	☐	☐	☐
Smoked during pregnancy	☐	☐	☐
Length of pregnancy: _____ months	☐	☐	☐
Other pregnancy problems/illnesses Specify: _____	☐	☐	☐

Birth/Early Infancy	Yes	No	Unknown
Born prematurely	☐	☐	☐
Born with cord around neck	☐	☐	☐
Injured during birth	☐	☐	☐
Had trouble breathing	☐	☐	☐
Turned blue (cyanosis)	☐	☐	☐
Was a twin or triplet	☐	☐	☐
Had an infection	☐	☐	☐
Had seizures (fits, convulsions)	☐	☐	☐
Needed oxygen	☐	☐	☐
Was very jittery	☐	☐	☐

Childhood Health Issues	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Seizures (convulsions) or spells	☐	☐	☐		☐
High fevers (over 103° F. or 39° C.)	☐	☐	☐		☐
Head injury	☐	☐	☐		☐
Asthma	☐	☐	☐		☐
Trouble with hearing	☐	☐	☐		☐
Trouble with vision	☐	☐	☐		☐
Lead poisoning	☐	☐	☐		☐
Other poisoning or overdose	☐	☐	☐		☐
Other serious illness	☐	☐	☐		☐
Other hospitalizations	☐	☐	☐		☐

Functioning	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Poor appetite	☐	☐	☐		☐
Constipation	☐	☐	☐		☐
Stomach aches	☐	☐	☐		☐
Trouble falling asleep	☐	☐	☐		☐
Trouble staying asleep	☐	☐	☐		☐
Overactivity	☐	☐	☐		☐
Head banging	☐	☐	☐		☐
Rocking in bed	☐	☐	☐		☐
Temper tantrums	☐	☐	☐		☐
Self-destructive behavior	☐	☐	☐		☐
Difficulty in being comforted or consoled	☐	☐	☐		☐
Stiffness or rigidity	☐	☐	☐		☐
Looseness or floppiness	☐	☐	☐		☐
Crying often and easily	☐	☐	☐		☐
Shyness with strangers	☐	☐	☐		☐
Irritability	☐	☐	☐		☐
Extreme reaction to noise or sudden movement	☐	☐	☐		☐
Attention problems	**Yes**	**No**	**Unknown**	**If yes, age first noted**	**If yes, still occurring?**
Can concentrate for only a short time unless things are very interesting	☐	☐	☐		☐
Understand the main ideas of things but misses important details	☐	☐	☐		☐
Does work or performs many tasks carelessly without thinking	☐	☐	☐		☐
Learns a new skill well one day and then can't seem to do it a few days later	☐	☐	☐		☐
Receives very unpredictable (inconsistent) grades or test scores in school	☐	☐	☐		☐
Can work well only on things he/she really enjoys doing or thinking about	☐	☐	☐		☐
Often doesn't notice when he/she makes mistakes	☐	☐	☐		☐
Seems not to realize when he/she is disturbing someone	☐	☐	☐		☐
Doesn't do much better after punishment or correction	☐	☐	☐		☐
Makes comments about or is distracted by background noises or unimportant things	☐	☐	☐		☐
Seems to want things right away and/or is hard to satisfy	☐	☐	☐		☐
Annoys or bothers other children	☐	☐	☐		☐
Behavior is variable and hard to predict	☐	☐	☐		☐
Is a troublemaker; bullies others	☐	☐	☐		☐

Behaviors	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Has bad dreams	☐	☐	☐		☐
Is often very quiet or withdrawn	☐	☐	☐		☐
Is often "down" on himself/herself	☐	☐	☐		☐
Is often tired	☐	☐	☐		☐
Speaks unclearly, stutters, or stammers	☐	☐	☐		☐
Wets bed or pants often	☐	☐	☐		☐
Soils underwear or has accidents with bowel movements	☐	☐	☐		☐
Is often too neat or orderly	☐	☐	☐		☐
Is often too concerned about cleanliness	☐	☐	☐		☐
Often plays with matches	☐	☐	☐		☐
Destroys objects at home	☐	☐	☐		☐
Destroys objects away from home	☐	☐	☐		☐
Is fearless	☐	☐	☐		☐
Is cruel to animals	☐	☐	☐		☐
Is not liked by other children	☐	☐	☐		☐
Feels ill on school mornings	☐	☐	☐		☐
Has eating problems (either overeats or undereats)	☐	☐	☐		☐
Is preoccupied with food or diet	☐	☐	☐		☐
Is part of a clique or gang that causes trouble	☐	☐	☐		☐
Other behaviors not noted above	☐	☐	☐		☐
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?	☐	☐	☐		☐
Have you ever had concerns about your child's sexual development or behaviors?	☐	☐	☐		☐

IF THERE ARE INDICATIONS OF ISSUES, PLEASE EXPLAIN

Child's school functioning

Education classification

Does your child have an IEP for special education services? ☐ YES ☐ NO

If no, has your child ever been tested and determined not to need services? ☐ YES ☐ NO

Regular education classroom, no special services ☐ YES ☐ NO

If no, check all that apply below.

- ☐ Early Childhood Spec. Ed./Developmental Delay
- ☐ Special Learning Disability
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Speech or Language Impaired
- ☐ Physically Impaired
- ☐ Emotional/Behavioral Disorder
- ☐ Developmental/Cognitive Disability
- ☐ Special learning disability
- ☐ Autism Spectrum Disorder
- ☐ Traumatic brain injury
- ☐ Other health impaired
- ☐ Unsure
- ☐ Current 504 plan
- ☐ Other: _____

COMMENTS ON EDUCATIONAL CLASSIFICATION

Child's legal history

Does your child have a history of legal charges? ☐ NO ☐ YES

IF YES, DESCRIBE CHARGES

Is the child currently on probation? ☐ NO ☐ YES

Has the child ever been on probation? ☐ NO ☐ YES

Has the child ever been court-ordered into chemical health or mental health treatment? ☐ NO ☐ YES

Has the child ever had involvement with Child Protective Services (CPS)? ☐ NO ☐ YES

IF YES, DESCRIBE

NAME OF CPS CASEWORKER(S) ASSIGNED TO FAMILY (IF APPLICABLE)

☐ NONE REPORTED

NAME OF GUARDIAN AD LITEM (GAL) OR COURT APPOINTED SPECIAL ADVOCATE (CASA) ASSIGNED TO FAMILY

☐ NONE REPORTED

Child's trauma history

Has your child experienced or witnessed any of the following? (check all that apply)

- ☐ Car accident
- ☐ Other accident
- ☐ Physical illness
- ☐ Physical abuse
- ☐ Domestic violence/abuse
- ☐ Emotional abuse
- ☐ Physical neglect
- ☐ Sexual assault/molestation
- ☐ Community violence
- ☐ Fire
- ☐ Natural disasters
- ☐ Other:
- ☐ None of the above

Child's mental health treatment history

Previous mental health treatment ☐ NO ☐ YES If yes, please list reason for treatment, and dates:

Reason	Dates

Currently on any medication(s)? ☐ NO ☐ YES

IF YES, PLEASE LIST AND BRING MEDICATIONS TO NEXT APPOINTMENT

PRIMARY CARE PHYSICIAN			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE
OTHER PRESCRIBING PHYSICIAN(S)			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE

Child's alcohol and drug history

Do you have any concerns about your child's use of alcohol or drugs? ☐ NO ☐ YES

Do you have any other issues or concerns about your child you would like to have addressed? ☐ NO ☐ YES

COMMENTS

Family Environment/Relationships

Please indicate below the best descriptions of parent-child relationships.

Parent-Child (Client) Relationship(s)	**P** = Primary household		**S** = Secondary household	**B** = Both	
Parent-child conflict	NONE – MILD	MODERATE	SEVERE		
Issues with supervision and monitoring of child	ALWAYS	USUALLY	INCONSISTENTLY	RARELY	
Cooperation between parents regarding child-rearing	ALWAYS	USUALLY	INCONSISTENTLY	RARELY	NOT PERTINENT
Parent positive activities with child	FREQUENT	OCCASIONALLY	INFREQUENT		
Parent satisfaction with relationship	SATISFIED	NEUTRAL	DISSATISFIED		
Child satisfaction with relationship	SATISFIED	NEUTRAL	DISSATISFIED		

COMMENT ON PARENT-CHILD RELATIONSHIPS (describe further if needed)

Please indicate below the best descriptions of sibling-child relationships.

Sibling-Child (Client) Relationship(s) ☐ NO SIBLINGS	**P** = Primary household	**S** = Secondary household	**B** = Both
Child-sibling conflict	NONE – MILD	MODERATE	SEVERE
Sibling(s) positive activities with child	FREQUENT	OCCASIONAL	INFREQUENT
Sibling(s) satisfaction with relationship	SATISFIED	NEUTRAL	DISSATISFIED
Child satisfaction with relationship	SATISFIED	NEUTRAL	DISSATISFIED

COMMENT ON SIBLING-CHILD RELATIONSHIPS (describe further if needed)

Please indicate below the best descriptions of parent marital or couple relationships.

Parent Marital or Couple Relationship(s) ☐ NOT APPLICABLE	**P** = Primary household	**S** = Secondary household	**B** = Both
Marital or couples conflict	NONE – MILD	MODERATE	SEVERE
Marital or couples satisfaction	SATISFIED	NEUTRAL	DISSATISFIED

COMMENT ON PARENT MARITAL OR COUPLES RELATIONSHIPS (describe further if needed)

Other Family Concerns			If yes, indicate:		
	No	Yes	Parent	Sibling	Other
Family member health problems	☐	☐			
Family member disability	☐	☐			
Family member legal issues	☐	☐			
Family financial concerns	☐	☐			
Family member alcohol abuse	☐	☐			
Family member substance abuse	☐	☐			
Family member anxiety	☐	☐			
Family member depression	☐	☐			
Family member ADHD	☐	☐			
Family member mania	☐	☐			
Family member schizophrenia/other psychosis	☐	☐			
Significant family stressors (moves, deaths, divorce, loss of employment)	☐	☐			

COMMENT ON OTHER FAMILY CONCERNS AND INFORMATION RELATING TO FINANCIAL STATUS (Specify problems that impact child's needs.)