Dr. Sharon M. Phillips & Associates, LLC
8080 Beckett Center Drive, Suite 325
West Chester, Ohio 45069
(513) 860-0801

Rev. 4/10

CONSENT TO TREAT A MINOR

This is a consent to perform professional therapeutic services for children and adolescents.

I, ___________________________________, consent to Dr. Sharon M. Phillips & Associates, LLC
(Print name)

to provide therapy services to my son/daughter, ______________________________.
(Print child's name)

I understand my son/daughter may be asked to complete several forms which will help my therapist to better understand his/her symptoms and that individual or family therapy may be included in the treatment process.

______________________________ ______________________________
Signature of Parent/Guardian Print Child's Name

______________________________ ______________________________
Child's Date of Birth Signature of Child (if age 13 or older)

____
Date Signed

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CHILD/ADOLESCENT INFORMATION QUESTIONNAIRE
AND CONSENT TO RECEIVE TREATMENT

Rev. 4/10

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully, and ask for clarification if you do not understand an item.

Child's Name ______________________________________
First Middle Last

Child's Date of Birth: ____/____/____ Child's Age: ___________

Child's Grade Level: ________________ School: __________________________________

Child lives with: _____ Both parents _____ Mother _____ Father _____ Legal guardian

If separated or divorced, who has custody of child? ___________

MOTHER'S INFORMATION Mother's Name: __________________________ Age: ________

Marital Status:_____Single _____Married _____Separated _____Divorced _____Widowed

Mother's Address:____
(Street) (Apartment) (City) (State) (Zip)

Home Phone: _____________________ Cell: ________________ E-mail: ________________________
*Is it okay to call or leave a message at home? _____ yes _____ no
*Is it okay to call or leave a message on your cell? _____ yes _____ no

Mother's Occupation: _______________________Work telephone number ____________________

Mother's Employer: __________________________ Address: _____________________________________
*Is it okay to call or leave a message at work? _____ yes _____ no

Please list all individuals living with mother:

Name **Age** **Relationship** **Occupation**

____
____
____
____
____

FATHER'S INFORMATION Father's Name: _________________________ Age: _______

Marital Status:_____Single _____Married _____Separated _____Divorced _____Widowed

Father's Address:____
(if different from mother's) (Street) (Apartment) (City) (State) (Zip)

Home Phone: _____________________ Cell: ________________ E-mail: ________________________

*Is it okay to call or leave a message at home? _____ yes _____ no
*Is it okay to call or leave a message on your cell? _____ yes _____ no

Father's Occupation: _______________________Work telephone number ____________________

Father's Employer: ___________________________ Address: _____________________________________
*Is it okay to call or leave a message at work? _____ yes _____ no

Please list all individuals living with father (if different from mother's home):

Name **Age** **Relationship** **Occupation**

____
____
____

INSURANCE INFORMATION

If you believe insurance may cover a portion of your visits here, please complete the following information:

Policy Holder ____ Policy Holder D.O.B. ___/___/___
First Middle Last Policy Holder SS#: ___________________

Insurance Company: _________________________________ Member I.D. #: ______________________

Group No.: ________________________________ Company where Policy Holder works: ________________

CHILD'S INFORMATION

Briefly describe your reason for seeking help for your son/daughter: ___________________________________
____
____

When was your child last examined by a physician? _________________________________

Child's physician's name:____

Child's physician's address: ____

List any major health problems for which your child is currently receiving treatment: ___________________
____
____

List any current medications/purpose: ____
____

Has your child ever received psychiatric or psychological help or counseling of any kind before? __________

If yes, please explain and give dates: ____
____
____

Please check any and all of the following problems which pertain to your child:

_____Nervousness	_____Depression	_____Fears
_____Shyness	_____Sexual Problems	_____Suicidal Thoughts
_____Separation	_____Divorce	_____Distractibility
_____Drug Use	_____Alcohol Use	_____Friends
_____Anger	_____Self-Control	_____Unhappiness
_____Sleep	_____Stress	_____Work
_____Relaxation	_____Headaches	_____Tiredness
_____Legal Matters	_____Memory	_____Grief/Loss
_____Energy	_____Making Decisions	_____Spiritual Concerns
_____Loneliness	_____Inferiority Feelings	_____Concentration
_____School Behaviors	_____Grades	_____Health Problems
_____Nightmares	_____Appetite	_____Stomach Trouble
_____Family Problems	_____Abuse/Neglect	_____Defiant Behavior
_____Bedwetting/Soiling	_____Thoughts	_____Fighting
_____Self-injurious Behavior	_____Weight	_____Other: ________________

Please add any additional information which you feel may be useful:

____

____

____

____

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR COMPLETE PAYMENT OF SERVICES RENDERED AND I ACCEPT THAT RESPONSIBILITY.

Signature: ______________________________ Date: ________________

(Parent/Guardian)

How did you hear about us? _____ Friend/Relative _____Church _____Advertisement _____ Physician

_____ Phone Book _____Presentation/Seminar _____Insurance

_____ Other: (Please specify: _________________)

Will you allow us to send a thank-you to the person who referred you? _____ yes _____ no

If so, please provide the name and address below: