Confidential Family Data Report

____
CHILD'S FULL GIVEN NAME

Dear Parents:

This Confidential Family Data Report has been designed to assist us in better understanding your family and the reason why you came to us. Careful consideration of each question will enable you to provide us with valuable information concerning your family. Your comments will remain strictly confidential.

As parents, please confer jointly on each question and answer each one that is appropriate to your family. Cross out the number in front of those questions that do not apply to you. Please feel free to elaborate upon any answer you give and to add additional remarks at the end of the questionnaire.

____________________	__________/_________	___________________
TODAY'S DATE	Gender/AGE	CHILD'S NICKNAME *(IF ANY)*
_____________/_______	______/______/_______	___________________
SCHOOL GRADE	DATE OF BIRTH	SOCIAL SECURITY #

Home Address ____________________________City ______________ ST ___ ZIP ____________

Home Phone (______) ______-__________ Cell Phone (____) ________-_______

Work Phone (______) ______-___________ E-Mail ______________________________

HOUSEHOLD COMPOSITION
Please list the persons presently living with the client (including you).

NAME	AGE	RELATIONSHIP	SCHOOL LAST ATTENDED/ EDUCATIONAL LEVEL
____________________________	_____	______________	___________________________
____________________________	_____	______________	___________________________
____________________________	_____	______________	___________________________
____________________________	_____	______________	___________________________
____________________________	_____	______________	___________________________

Please list immediate members of the family not currently in the home.

____________________________	_____	______________	___________________________
____________________________	_____	______________	___________________________
____________________________	_____	______________	___________________________
____________________________	_____	______________	___________________________

Child/Adolescent Developmental History
(for ages 17 and younger)

What was your child's birth weight?
________ lbs. ________ oz. ❑ Unknown

Was delivery normal?
❑ Yes ❑ Unknown
❑ No; specify ________________________

Did the birth mother experience any physical or emotional problems during pregnancy?
❑ Yes; specify _____________________

____

❑ No ❑ Unknown

Were medications taken during pregnancy?
❑ Yes; specify _____________________

____

❑ No ❑ Unknown

Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?
❑ Yes; specify _______________________

____

❑ No ❑ Unknown

Did the baby experience any problems immediately after birth?
❑ Yes; specify _______________________

____

❑ No ❑ Unknown

Has your child ever required hospitalization?
❑ Yes; specify _______________________

____

❑ No ❑ Unknown

Is there any history of physical, sexual or emotional abuse?
❑ Yes; specify _______________________

____

❑ No ❑ Unknown

Is there a history of prolonged separations or traumatic events?
❑ Yes; specify _______________________

____

❑ No ❑ Unknown

At what age did your child do the following?
(Italicized areas reflect normal development)
________ smiled *(6 mths)*
________ sat alone *(6 to 10 mths)*
________ talked in sentences *(30 to 36 mths)*
________ walked by self *(12 mths)*
________ held head up *(3 to 4 mths)*
________ fed self *(2yrs)*
________ crawled *(6 to 10 mths)*
________ rode a bike *(6 yrs)*
________ rolled over *(6 mths)*

________ talked in single words *(18 to 24 mths*)
________ pulled up *(6 to 10 mths)*
________ established toilet training *(2 ½ to 4 yrs)*

How would you describe your child's approach to new situations?

- ❑ Positive, jumps right in
- ❑ Withdrawn, tends not to participate
- ❑ Slow to warm up; cautious

How would you generally describe your child's overall mood?

- ❑ Positive (happy, laughing, upbeat, hopeful)
- ❑ Negative (depressed, cranky, angry, hostile)
- ❑ Mixed but more positive, than negative
- ❑ Mixed but more negative than positive

Which school is your child currently attending?

____

Is your child currently receiving special services in this school?

- ❑ Yes; specify ________________________

  ____

- ❑ No

Has your child ever failed a class or been held back for academic reasons?

- ❑ Yes; specify grade: ____
- ❑ No

Is your child expected to pass this school year?

❑ Yes ❑ No

PARENTAL HISTORY

Alcohol or Drug use: Mother Yes No Father Yes No

If yes, Please explain: ____

Occupation of:

FATHER ___________________________DOB _____/_____/_____ Work Phone ____-____-_______

MOTHER ___________________________DOB _____/_____/_____ Work Phone ____-____-______

Parent(s),

Have you been seen by a therapist before? Y/N By Whom? ____________________ When? _________

Who referred you here? ____

How many years have you been married? ___________ List previous and/or subsequent marriages of both parents (include dates).

____

____

____

1. We consider our child's problem to be
____
____

____
____
____

2. When and under what circumstances was the problem first noticed ?
____
____
____

3. Has the problem become better or worse? *(Describe any changes.)*
____
____
____

4. As the parents have you ever believed that you may have partially been responsible for your child's problem? *Yes* _____ *No* _____ *(If "yes", please explain)*
____
____

5. Did either of you (Parents) have similar difficulties as a child? *Yes* _____ *No* _____ *(If :yes: please explain)*____
____

6. Has your child had temper tantrums, fears, thumb sucking, sleep disturbances, head banging, running away from home, or other distressing behavior? *(Please circle)* Others (please explain)
____

7. Was your child, as a baby, a happy infant or was he difficult to manage?
____

8. Were your child's developmental "milestones" (when child first sat, crawled, stood, walked, talked, etc.) similar to his brothers, sisters, cousins or neighborhood children? If not, please describe.
____
____

9. Indicate any significant illnesses, hospitalizations or surgical procedures during your child's life.
____
____

10. How does your child get along with his/her brothers and sisters? *(Be Specific)*
____
____
____

11. Does your child have many friends? ____
12. How does your child typically act with children his own age?
____

13. How is your child's school achievement? *(Be Specific)*
____
____

14. How many separate schools have been attended? _______________ What is your opinion of the quality of the schools and the teachers that have been involved with your child's education?
____
____
____

15. How does your child get along with his/her present teacher?
____

16. What have been your child's "chores" or duties and has he been dependable?
____
____

17. What have been your child's hobbies, interests, special talents, or accomplishments?
____
____

18. The principle disciplinarian in our home is: (a) Mother ____ (b) Father _____ (c) Other (Explain)
____

19. Do you and your spouse agree on the use of limit setting or discipline? Yes _____ No _____ *(Please Explain)*____
____
____

20. What forms of discipline have been most effective? ____________________________________
21. How does your child generally spend his leisure time?
____

____
____

22. What activities do your family enjoy together?
____
____

23. How often do you have an "evening out" without your child and his siblings? ___________ What type of activities do you both enjoy ____
____
____

24. Current religious preference: ____
25. Church attendance: Regular _________; Frequent _________; Occasional _________; Never _________
26. I would describe the relationship between my child and myself as *(Check appropriate spaces)*

		Mother	Father
a.	Very Close	_______________	_______________
b.	Close	_______________	_______________
c.	Tolerant	_______________	_______________
d.	Strained and Cold	_______________	_______________
e.	Other (Please specify)	_______________	_______________

27. How have you tried to cope with your child's difficulty: *(Check all appropriate comments.)*
    _____ Talking to the child.
    _____ Talking to the neighbors.
    _____ Talking to professional persons *(Who? ____)*
    _____ Ignoring it.
    _____ Other *(Specify)* ____
28. In handling the difficulty with our child we have:
    _____ Been unable to reach our child.
    _____ Felt we have grown further apart.
    _____ Felt it was a waste of time.
    _____ Felt it brought us closer to our child.
    _____ Other *(Please specify)* ____
    ____

29. At this time, are you and your spouse having marital difficulties? _____ *(If "YES", please explain.)*
____
____

30. Has your child ever been psychologically tested? _____ *(If "YES", When?_____________________________, Where? ____)*
31. What goals do you have in mind in coming to this office?
____
____
____

32. In filling out this questionnaire together, were there any answers to questions on which you and your spouse could not agree? _____ *(If "YES", please explain.)* ____
____
____

33. Please add any other factors which, to you, seem to be of special meaning in your child's life.
____

34. Does your child have a history of Alcohol or Drug use? If yes, please explain. ___________________________
35. Does your child have a history of Physical or Sexual abuse? If Yes, please explain _______________________
____

36. Please, share any additional comments. ____
____
____

____
Parent Signature

____
Parent Signature

(If only one parent completed the form, please indicate.)

Authorization for Treatment of Minors/Dependents

In Tennessee a person who is 16 years or older can legally give his/her consent receive health services (TCA 33-6-101). Individuals under the age of 16 years are legal minors and must have a parent or legal guardian authorize professional services.

I certify that I am the Parent or legal guardian of _______________________________________ who is a minor or dependent under the laws of the state of Tennessee I Authorize Cassius and Associates Wellness Services PLLC therapists to provide psychological treatment to:______________________________ such treatment may include, but is not limited to, individual therapy, group therapy, family therapy, hypnotherapy, psychological testing and evaluations, and or other specialized procedures, which are generally accepted in the field of counseling and clinical social work.

Treatment Agreement

I/We understand and agree to the following as it relates to the treatment of the above named patient:

1. That entering into psychological treatment is a voluntary activity. Although parents may initiate therapy for their children, there is always the choice to participate.
2. That therapy is built on honest disclosure by all involved.
3. That children and adolescents, like adults, have the right to confidentiality. Cassius and Associates therapist will not disclose the details of the patient's therapy without that patient's consent, unless the safety of that patient or others is thought to be at risk. Exceptions to this include suspected drug abuse or neglect that has not been reported. Of course, the patient is free to disclose as he or she feels fit.
4. That Cassius and Associates therapist does not provide emergency psychiatric care. I/We have the responsibility to deal with emergency situations by either calling 911, proceeding to an emergency room, or putting into place some other other designated emergency plan. After hours, Cassius and Associates therapist may be reachable by leaving a message, through e-mail, or as designated by the therapist. I/We understand that Cassius and Associates Therapist will respond as he/she is able to urgent situations that may arise.
5. That should therapy not lead to desired outcome; I/We will have the responsibility to communicate that concern to Cassius and Associates therapist. I/We may be given information about treatment options and are welcome to pursue them at any time.

Signatures below indicate review, agreement, and consent to all above policies.

Patient signature:____Date:_________

Responsible Party/Parent
Signature:____Date:_________

Fees:
45-60 min. session - $160.00 (*SSCALE ____________________PER EC ____________ Date _____/_____/_____)*
Group therapy: $50-$75 per session.
ADHD Evaluation and Report $400.00 may take up to 3 sessions, ***this does not include educational/IQ testing.***
Report Fee: $ 100.00 - $250.00
Court Appearance $200.00/hr. plus travel time unless otherwise contracted
Hypnotherapy: $500.00 for 4 sessions prepaid or $160 per session ***Hypnotherapy is not covered by insurance***

The sessions will usually consist of 50 minutes and will be once per week. It is important for you, the client, to recognize that when you make an appointment, we are reserving that time for you. If you are late, that cuts down on your therapy time. If you miss an appointment, that is time that could have been scheduled for another client. Therefore, it is necessary for us to CHARGE YOU for appointments where we have not been given TWENTY-FOUR HOUR CANCELLATION NOTICE. If you do need to cancel, we appreciate AS MUCH NOTICE AS POSSIBLE, so that someone else who may be waiting for a cancellation can arrange to come in. You may call at any time to notify us of a cancellation by leaving a message on our voice mail as it will leave the time and date of your call. Should finances become a reason for discontinuing your therapy please let your therapist know. In the event that this office must seek outside help to collect on an account the client will pay for these services.

____
(Your Signature and Date)

PLEASE COMPLETE THE FOLLOWING IF INSURANCE IS TO BE FILED.

Insured's Name ____
Last M.I. First

Insured's Address ____
Street City ST ZIP Code

Insured's Telephone ____
Home Work CELL

Insured's Date of Birth _________/_________/___________ Insured's S.S.N. _______/_______/_______

Patient's relationship to the insured ______________________________

Insured's Employer ____

Insured's I.D. # ____ Group # ___________________

Insurance Company ____
(Please provide a copy of your insurance card at the time of your appointment)

If your insurance pays for a Masters level therapist, we still require payment at the time of service. We can submit the forms for you or supply you with an itemized statement and diagnosis, which you can submit for reimbursement. It is your responsibility to submit your own insurance claim forms.
REGARDING INSURANCE, PLEASE REMEMBER THAT THE INSURANCE IS YOURS, NOT OURS, AND THE PAYMENT OF FEES REMAINS YOUR RESPONSIBILITY.

If your child has been referred by DCS or JC, please complete the following:

Caseworker ____________________________ Phone # _____________________ FAX ______________________

Social worker ___________________________ Phone # _____________________ FAX _____________________

Additional Contact ____

Cassius & Associates
815 MT. MORIAH ROAD
MEMPHIS, TN 38117
PHONE: 901-685-5491
FAX: 901-685-8292

CREDIT/DEBIT CARD BILLING AUTHORIZATION FORM (**OPTIONAL**)

If you desire to pay by credit/debit card automatically, instead of check, cash or presenting a card at the time of visit – Please complete and sign this authorization form. All fields are required. I will bill your credit/debit card automatically for the agreed upon amount. A receipt will be provided either by email. You may cancel this automatic billing authorization by contacting this office via email, or voice mail. A notification of at least 5 business days prior to billing date is required.

Credit/Debit Card Information (all information below is required)

Credit Card Holder Name (as shown on credit card): ____

Billing address:____

Street City/state Zip code

Phone#____ Email address____

Credit Card Type: [ ] **VISA** [ ] **Master Card** [ ] **American Express** [ ] **Discover**

Credit Card #: ____ Expiration Date: _______________________

CVC# (3 digits on the back of the card)____________ CID #(**AMEX ONLY**: 4 digit code printed on the front of the card)________

Cardholder's signature: ____
Date:______________________________

Payment Options (please specify payment detail **IF KNOWN – e.g.** Copay amount**)**

ONCE	Bill my credit card once for the following amount: $______________ Date:________________
MONTHLY	Bill my credit card once per month for the following amount: $__________________ Start & End Date: _____________________________________
CUSTOM	Bill my credit card after each session for the balance owed. Other Instructions: ____ ____ ____

I authorize Cassius and Associates Wellness Services PLLC to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services provided by Cassius and Associates Wellness Services PLLC, as authorized by the client/guardian/legal representative. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Responsible Party Signature:____ Date:________________