Jewish Family SERVICES

Child-Adolescent Therapy - New Client Form

Please complete all paperwork prior to your appointment. Insurance card must be presented at each appointment.

Client Legal Name or as listed on insurance: _____ **Client DOB**: _____/____/_____

Client Address: _____

City: _____, **County**: _____, **Zip Code:** _____

Gender:_____ **What pronouns do you use?** _____**(ex.,He/Him; She/Her; They/Them)**

Race: _____ **Religion:**_____

How did you hear about JFS: ☐Friend/Family ☐JFS Marketing ☐Jewish Agency ☐Non-Jewish Agency ☐Physician ☐Self ☐Clergy ☐Synagogue: which one _____☐Volunteer ☐Website ☐Psychology Today ☐Other_____

Yearly Household income : $_____, Number of people living in home : Adults: _____, children_____

Guardian #1

Name : _____ Relationship _____

Address: (if different from client)_____

City: _____, **County**: _____ **, Zip Code:** _____

Preferred Phone: _____ ☐ Check (if JFS is authorized to leave message)

Other Phone: _____ ☐ Check (if JFS is authorized to leave message)

Email: _____ ☐ Check (if JFS is authorized to send message/ information)

GUARDIAN #2:

Name : _____ **Permission to speak to Father? ☐Yes ☐No**

Address: (if different from client)_____

City: _____ **County**: _____ **Zip Code:** _____

Preferred Phone: _____ ☐ Check (if JFS is authorized to leave message)

Other Phone: _____ ☐ Check (if JFS is authorized to leave message)

Email: _____ ☐ Check (if JFS is authorized to send message/information)

Please answer the following questions and attach all signed Court Orders outlining rules of custody and medical treatment.

Primary Custody: ☐*Guardian #1* ☐ *Guardian #2* ☐*Joint/Shared*

Primary Care Physician : _____ **Phone** : _____

Preferred Hospital / Clinic : _____

Primary Insurance Carrier: _____**Name of Policy Holder** : _____

Policy # : _____ **Group #** _____ **DOB of Policy Holder** : _____/_____/_____

Secondary Insurance Carrier : _____**Name of Policy Holder**: _____

Policy # _____ **Group #** _____ **DOB of Policy Holder** _____/_____/_____

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In Case of Emergency, Please Contact the Following Individual :

Name : _____ **Relationship**:_____

Preferred Phone Number : _____

I hereby give permission for JFS to provide, seek, and consent to emergency treatment for the client names above, as may be necessary.

_____ **Date** ___/___/_____

Signature of Guardian #1 **Printed Name of Guardian #1**

_____ **Date** ___/___/_____

Signature of Guardian #1 **Printed Name of Guardian #2**

I hereby authorize, _____, relationship_____ to speak to Jewish Family Services of Greater Charlotte's on behalf of _____, my minor child.

_____ **Date** ___/___/_____

Signature of Guardian #1 **Printed Name of Guardian #1**

_____ **Date** ___/___/_____

Signature of Guardian #1 **Printed Name of Guardian #2**

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Client Legal Name: _____ Client DOB: ____/____/_____

PLEASE INITIAL THE FOLLOWING :

____ I have read and agree to the Office Policies and guidelines, Clients Rights & Privacy Practices (you may view a copy of these on the JFS website or request a copy from the JFS office) and do so annually.

____ I understand that I must complete the following forms prior to consultation and update them annually:

1. Emergency Information
2. Clinical Surveys
3. Policies and Guidelines

____ I grant permission for JFS and their representatives, to communicate with me via email as indicated below.

I confirm that the email address that I have given is a private email and I release JFS from any responsibility for access to my private email by any other person not authorized by me. See JFS Email Informed Consent Policy.

I authorize my child/ward's therapist/case worker to communicate with me via email. ☐Yes ☐ No

I would like to receive email communication regarding JFS services and programs ☐Yes ☐ No

____ All fees or costs have been explained to us/me.

CLIENT CONSENT FOR SERVICES : PLEASE INITIAL EACH LINE :

____ We/ I agree to allow Jewish Family Services of Greater Charlotte (JFS) to provide services to my child/my ward's.

____ We/I will participate in developing a service plan, which will identify goals to work toward, time frames and methods to achieve these goals

____ JFS services have been described to me/us.

____ We/I have been informed about the alleged benefits, potential risks and possible alternative methods of treatment and the ways that JFS can support the achievements of the desired outcomes.

By signing below, I certify that I have answered the questions above honestly and accurately.

_____ **Date ___/___/_____**

Signature of Guardian #1 **Printed Name of Guardian #1**

_____ **Date ___/___/_____**

Signature of Guardian #1 **Printed Name of Guardian #2**

_____ Date ___/___/_____

Signature of JFS Staff member

Updated 1-1-2021

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CHILD/ADOLESCENT THERAPY QUESTIONNAIRE

Client Legal Name _____ Client DOB: _____/_____/_____ __

School Attending: _____ Grade: _____

1. MAIN CONCERNS (PLEASE CHECK ALL APPROPRIATE BOXES):

- ☐ Limited eye contact
- ☐ Difficulty following directions
- ☐ Emotionally over-reactive
- ☐ Difficulty initiating/maintaining social conversation
- ☐ Trouble reading social cues
- ☐ Limited problem-solving skills
- ☐ Difficulty regulating impulses or responses
- ☐ Limited pretend play
- ☐ Difficulty with personal space
- ☐ Trouble with communicating needs/feelings
- ☐ Difficulty with staying on topic
- ☐ Other: _____

2. EDUCATIONAL INFORMATION

School(s) attended (Pre-K – 12): _____

Were there any problematic situations at school: _____

3. MEDICAL HISTORY

List current medications including prescribed, over the counter, herbs, vitamins.

Medications	Currently Using? Y/N	Reason for Medication	Outcome

4. MENTAL HEALTH HISTORY

List your child's mental health history, including current/past psychiatrists, psychologists, hospitalizations, etc.

Facility/Name of Provider	Treatment Dates	Symptoms/Reasons for Treatment	Outcome

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5. CURRENT SITUATION

Describe any recent family changes or significant losses/traumas: _____

_____

_____

_____

_____

Describe your child's strengths: _____

_____

_____

_____

_____