SproutCounseling

Child/Adolescent Registration

Child Information:

Last Name:	First	Middle Initial

Sex M/F	Age:	Date of Birth:

Address:

City:	State:	Zip:

Home Phone:	Work:	Cell:

Email addresses: Mother: Father: Teen/child (optional):

Best way to contact? (circle all that apply) Home Work Cell Email	Is it OK to leave a message? Yes No

Primary Physician:

Physician address and phone no.:

Mother's information

Last Name	First:	MI:

Address:	City	State

Phone	Work	Cell

Occupation:	Employer

Relationship Status (circle) Single Married Separated Divorced

Father's information

Last Name	First:	MI:
Address:	City	State
Phone	Work	Cell
Occupation:	Employer	
Relationship Status (circle) Single Married Separated Divorced		

Emergency Contact:	Phone:	Relationship:

INSURANCE INFORMATION
ONLY IF FILING WITH
BLUE CROSS/BLUE SHEILD

Subscriber's full name:	Birth date: / /	Is the subscriber responsible for the bill? ☐ Yes ☐ No	Home phone no.: ( )
Address (if different):			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Policy no.:	Group no.:	Subscriber's S.S. no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

I authorize Sprout Counseling to disclose and receive my information (and/or child's) to/from Blue Cross/ Blue Shield and it's affiliates and agents for the purpose of treatment, billing, and coordination. I understand that this authorization is voluntary and Sprout Counseling will not condition my treatment, payment, or enrollment or eligibility for benefits on signing this authorization.

Parent/legal Guardian Signature:

Child History

Current school attending: (name of school, county or private)	Grade Level:
List Past Schools: **Preschool:** **Primary:** **Middle:** **High:**	
What kind of grades does your child receive in school?	
What are your child's strengths and weaknesses?	
Who can I contact at the school that knows your child best? (Teacher, school counselor, principal?)	
What extracurricular activities is your child involved with? (sports, clubs, leadership training)	
Are there other significant adults relationships your child has outside of biological parents? (Step-parent, Grandparent, coach, Sunday school teacher, pastor, youth group leader)	
If you were to discipline your child, what methods do you use? (yelling, corporal punishment, taking things away, time outs, reasoning, grounding, etc.) How does your child respond to your methods?	
List siblings (biological and step). How does your child get along with his/er siblings and/or others? (5-wonderful, 4-good, 3-fair, 2-poor, 1-non-exsistant)	

Name:	Age	Grade	Relationship Quality

Develpmental

Was your child born at full-term?

- ☐ **Yes**
- ☐ **No**
- ☐ **Unknown**

If no, how many weeks was your child premature? If unknown, please explain.

Has your child had any developmental delays in their lifetime? (Please include any interventions needed such as PT, OT, Speech)

Medical

Is your child on any medications, both prescribed and over the counter?

- ☐ Yes
- ☐ No

If yes, please list medications and dosages:		
Medications	Dosage	Prescribing Physician

Please list any hospitalizations, surgeries, or major illnesses your child has experienced in their lifetime, including year:

Hospitalizations, surgeries or major illness:	Year

Is your child currently under the care of a physician for any medical related issues?

Emotional

Has your child seen a psychiatrist, psychologist, or another counselor before?

- ☐ Yes
- ☐ No

If yes, please list their name(s), dates seen (approx.), and reason you sought their help?

Is there any family history of mental illness (including ADD, ADHD)? Are there family members who you believe have a mental illness that are undiagnosed and what do you suspect their diagnosis to be?

Has your child experienced any trauma in their life?

Current Stressors for your child (for example, changes in school, family issues, friendships, deaths):

What does your child enjoy?
What does your child dislike?
When your child gets upset, what do they tend to do? How do you respond?
What are your hopes for your child?
Reason for seeking counseling and what would your child to accomplish through counseling?

Has your child experienced any of the following in the past 12 months:

	Yes	No
Depressed mood?		
Loss of interest?		
Loss of pleasure?		
Excessive fatigue?		
Loss of appetite?		
Thoughts of self harm?		
Thoughts of harming others?		
Trouble concentrating?		
Weight gain?		
Weight loss?		
Agitation?		
Feelings of unreality?		
Inappropriate elation?		
Inappropriate irritability?		
Grandiose notions?		
Increased pressured speech?		
Disconnected, racing thoughts?		
Markedly increased energy?		
Distractibility?		
Impulse control problem?		
Low self-esteem?		
Nervous habits?		
Social withdrawal?		

	Yes	No
Sleep disturbance?		
Panic attacks?		
Excessive muscle tension?		
Excessive nervousness?		
Difficulty breathing/smothering?		
Feeling very slowed down?		
Dizziness/Faintness?		
Tremors?		
Sweating?		
Tingling/Numbness?		
Flushes/Chills?		
Fear of losing control?		
Hallucinations (seeing or hearing things)?		
Suspiciousness of several people?		
Overly rapid/Skipping heartbeat?		
Difficulty remembering/Mind going blank?		
Unwanted recurrent persistent thoughts?		
Repetitive behavior or mental acts that you feel driven to perform?		
Behaviors or thoughts aimed at warding off some dreaded event?		
Confusion?		
Wide mood swings?		

Is there any other information I need to know about?

Notice Of Privacy Practices Acknowledgement

HIPPA Acknowledgement Notice of Privacy Practices

Print Name of Patient: _____
Patient's Date of Birth: _____

Sprout Counseling is required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices with respect to protected health information. I hereby acknowledge that I have reviewed the HIPPA Notice of Privacy document and understand that I may obtain a copy for my records upon request.

Signature of Patient/Legal Representative: _____
Today's Date: _____

E-mail Address of Patient/Legal Representative: _____
Cell Phone of Patient/Legal Representative: _____

Medical Information
Please let us know which number you would like us to call regarding your medical information. Note that this is the number where we will leave a message if we do not reach you.

Home Phone: _____ Cell Phone: _____ Both: _____

Appointment Reminders:
Please check if you'd like to received a reminder or text of your upcoming appointments. Appointment reminders are a courtesy, but in the event that you believe you have an appointment scheduled but have not received a reminder, you may call the office to confirm.

- ☐ I would like Email reminders
- ☐ I would like Text reminders(cell phone charges apply): #_____
- ☐ I would like both text and email
- ☐ NO REMINDERS