CONFIDENTIAL

CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

This questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information in order to help us in understanding your child. All information provided by you is strictly confidential and will only be released with your written consent. The Release of Information & Parental/Guardian Consent form is included at the end of this document.

PLEASE PRINT

Name of Person Completing this form: _____

Relationship to child or adolescent: _____

Child or Adolescent Information:

Legal Name of Child/Adolescent: _____

Nickname or name child routinely goes by: _____

Child's Date of Birth: _____ Age: _____ Gender: _____

Place of Birth: _____ Child's Nationality: _____

Immigration Status: _____

Child's Home Address:

P.O. Box _____ Postal Code: _____ Phone: _____

Street Address: _____ District_____

With whom does the child live? _____

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____

Referral Information:

What is the reason for the referral? _____

_____

_____

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Insurance Assignment

Insurance Company: _____

Policy Holder: _____

Insurance ID Number: _____

Parent/ Guardian 1: Name_____

Relationship to child: _____

Date of Birth: _____ Gender: _____ Age: _____ Nationality: _____

Place of Birth: _____ Immigration Status: _____

P.O. Box: _____ Postal Code: _____ Street Address: _____

Country of Residence: _____ City or District: _____

May we contact you by (check all that apply):

- ☐ Email: _____
- ☐ Home phone: _____ Leave a message? **Y/N**
- ☐ Work phone: _____ Leave a message? **Y/N**
- ☐ Cell phone: _____ Leave a message? **Y/N**

Occupation: _____ Employer: _____

Education Completed: _____

Physical Health: ____ Excellent ____ Good ____ Fair ____ Poor

Parent/ Guardian 2 Name_____

Relationship to child: _____

Date of Birth: _____ Gender: _____ Age: _____ Nationality: _____

Place of Birth: _____ Immigration Status: _____

P.O. Box: _____ Postal Code: _____ Street Address: _____

Country of Residence: _____ City or District: _____

May we contact you by (check all that apply):

- ☐ Email: _____
- ☐ Home phone: _____ Leave a message? **Y/N**
- ☐ Work phone: _____ Leave a message? **Y/N**
- ☐ Cell phone: _____ Leave a message? **Y/N**

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Occupation: _____ Employer: _____

Education Completed: _____

Physical Health: ____ Excellent ____ Good ____ Fair ____ Poor

Does either parent's job require him/her to be away from home long hours or extended periods?

_____

Marital Status of parents:

□Married □Divorced □Separated □Widowed □Single □Cohabitants

If married, how long have you been married? _____

If divorced, how long have the biological parents been divorced? _____

If parents are not married, who has legal custody of the child? _____

Is it full custody or joint? _____

Please explain:_____

Has either parent been married before or since? □Mother □Father

If yes, please provide dates of previous marriage(s), names, and ages of children from these marriages:

Mother: _____ Children & Ages: _____

Father: _____ Children & Ages: _____

Please list the names of the stepparents: _____

Is there a birth parent living outside the home: (circle one) MOTHER/ FATHER?

Name: _____ Where do they live? _____

If the birth parent(s) do not live in the child's home, how much contact does the child have with the parent not having custody, with stepsiblings, etc.?

_____

_____

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Siblings:

	Name	Age	Relationship	Living in Home?	School	Grade
1.	_____	_____	_____	**Y / N**	_____	_____
2.	_____	_____	_____	**Y / N**	_____ _	_____
3.	_____	_____	_____	**Y / N**	_____	_____
4.	_____	_____	_____	**Y / N**	_____ _	_____

Please indicate any special needs or concerns regarding the other children living in your home:

_____

_____

Please indicate any concerns you have regarding the child for whom you are seeking services and these sibling relationship(s):

_____

_____

Others:

List any other people who currently, or in the child's lifetime, have lived in your home.

	Name	Age	Relationship to Child	Years Living in Home
1.	_____	_____	_____	From _____ To _____
2.	_____	_____	_____	From _____ To _____
3.	_____	_____	_____	From _____ To _____
4.	_____	_____	_____	From _____ To _____

Are there any other people who have a significant role in how this child is raised?

_____

_____

Educational Information (List in chronological order all the schools your child has attended):

	Name	System	Year(s)	Grade	Special Ed?
1.	_____	_____	_____	_____	**Y/N**
2.	_____	_____	_____	_____	**Y/N**
3.	_____	_____	_____	_____	**Y/N**
4.	_____	_____	_____	_____	**Y/N**

Name of Current School: _____

School Telephone Number: _____ Present Year: _____

Principal's Name: _____

Current Teacher: _____ Email: _____

Describe any recent interventions/actions by the school:

_____

_____

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Has the child/adolescent been absent from school a lot? **Y / N**

If yes, please give reasons: _____

_____

What is the child/adolescent's attitude towards school?

_____

_____

What is the average amount of time that your child/adolescent spends on homework each night?

_____

Describe any problems with homework: _____

Has your child received tutoring? In what area? For how long?

_____

Please describe any behavioural areas of concern (i.e. following rules/routines, completing chores, interacting with other children?)

_____

Does your child's teacher have concerns about him/her? (please list):

_____

What is your child's favorite subject/class? _____

What is your child's least preferred subject/class? _____

Has your child ever repeated a grade? **Y/N** If yes, what grades? _____

If your child has been in Special Education/Learning Support did they have:

- ☐ I.E.P
- ☐ Psychological Evaluation
- ☐ Speech Evaluation
- ☐ Behaviour Intervention Plan
- ☐ Occupational Therapy Evaluation
- ☐ Physical Therapy Evaluation
- ☐ Other(s) _____

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If your child has been in Special Education/Learning Support please explain the services:

_____

_____

Psychological History:

Is there a history in your immediate or in the mother's or father's extended family, of the following and if so who?

Yes	No		Who
___	___	Autism Spectrum Disorder	_____
___	___	Learning Problem/Disabilities	_____
___	___	ADHD–Attention Problems	_____
___	___	Depression/Anxiety	_____
___	___	Behaviour Problems in School	_____
___	___	Psychosis/Schizophrenia	_____
___	___	Substance Abuse/Dependence	_____
___	___	Other Mental Health Concerns	_____

Has the child you are seeking services for been evaluated in the past? **Y/N**

If yes, please list the following information on the previous evaluation(s):

	Who	Type	When	Copy Available?
1.	_____	_____	_____	**Y/N**
2.	_____	_____	_____	**Y/N**
3.	_____	_____	_____	**Y/N**
4.	_____	_____	_____	**Y/N**

If yes, what were the general findings and recommendations?

_____

_____

Has anyone in your immediate or extended family experienced with:

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- ☐ Physical abuse, Explain _____
- ☐ Emotional abuse, Explain _____
- ☐ Verbal abuse, Explain _____
- ☐ Sexual abuse, Explain _____
- ☐ Sexual assault, Explain _____
- ☐ Alcoholism/drug use, Explain _____
- ☐ Other addictive behaviours, Explain _____

Discuss any significant recent life changes or past traumatic events that the child has experienced:

_____

_____

Please provide us with any other information that you feel would be helpful to us in understanding your child

_____

_____

Pre-natal and Delivery History:

Did the birth mother receive regular pre-natal care? **Y/N**

Where there any complications with the pregnancy? **Y/N**

If yes, please provide details: _____

_____

Was the birth at Full Term? **Y/N** If no, please provide details:

_____

Type of Delivery: Spontaneous/Induced Vaginal/C-Section

Complications in delivery? **Y/N** If yes, please provide details:

_____

_____

Birth Weight: ____ lbs ____ oz Apgar Scores: _____ _____

Concerns at Birth? **Y/N.** If yes, please provide details:

_____

_____

Is there any additional pre-natal or birth information that might be of assistance to us?

_____

_____

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Developmental History:

Please indicate the approximate age at which your child did the following:

Rolled over consistently _____

Giggled/smiled at parents _____

Sat up unsupported _____

Stood _____

Crawled _____

Walked Unassisted _____

Responded to name with eye contact _____

Said 1st word intelligible to strangers _____

Said two-three-word phrases _____

Used sentences regularly _____

Toilet trained during the day _____

Dry through the night (6+ months) _____

Dressed self _____

Please indicate if your child is experiencing any of the following:

- ☐ Problems with eating
- ☐ Isolated socially from peers
- ☐ Problems making friends
- ☐ Problems keeping friends
- ☐ Problems getting to sleep
- ☐ Problems controlling temper
- ☐ Problems sleeping through the night
- ☐ Trouble waking up
- ☐ Fatigue/tiredness during the day
- ☐ Nightmares
- ☐ Bed wetting
- ☐ Soiling
- ☐ Problems with authority
- ☐ Anxiety/Worry
- ☐ Unmotivated
- ☐ Stress from conflict with parents
- ☐ Legal situation (anyone in family)
- ☐ History of abuse
- ☐ Alcohol/Drug use/abuse
- ☐ School concentration difficulties
- ☐ Grades dropping/ consistently low
- ☐ Sadness or Depress

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Please explain all items endorsed_____

_____

_____

Medical History

Name of child's primary physician: _____

Practice Name: _____

Address: _____

Phone Number: _____ Email: _____

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had:

_____

_____

Does your child have any allergies? _____

List any medications your child is currently taking or has taken for extended periods (give dates and dosage level, if possible):

_____

_____

Child's current height: _____ Ft _____ Inches Weight: _____ lbs

With which hand does your child write? _____

Glasses□ Yes □No

Please list date of last vision test and who performed (pediatrician, optometrist, school):

_____

Ever been concerned about your child's hearing? □ Yes □No

Please list date of last hearing test and who performed_____

Has your child ever had a seizure? □ Yes □No

If yes, date of the last seizure: _____

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Other Professionals Involved:

Please provide information regarding any other professionals who may be involved in assisting with the current situation.

- ☐ Physician _____
- ☐ Psychiatrist _____
- ☐ Other _____

Please tell us about your Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.

_____

List any special abilities, skills, strengths your child has:

_____

Discipline Information:

Parents may use a wide range of discipline strategies with their children; some are listed below. Please rate how likely you are to use each of the strategies listed:

Intervention	**Very**	**Unlikely**		**Very Likely**		**Effectiveness**
Let situation go	1	2	3	4	5	_____
Take away a privilege (ex. No TV)	1	2	3	4	5	_____
Assign an additional chore	1	2	3	4	5	_____
Take away something material	1	2	3	4	5	_____
Send to room	1	2	3	4	5	_____
Physical punishment	1	2	3	4	5	_____
Reason with child	1	2	3	4	5	_____
Ground child	1	2	3	4	5	_____
Yell at child	1	2	3	4	5	_____
Send to time out	1	2	3	4	5	_____
List anything else you may do:						
_____	1	2	3	4	5	_____
_____	1	2	3	4	5	_____

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Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Please circle the LEAST effective.

General Information:

Please list the five things you would like for your child to do more or and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviours such as do household chores, care for brothers and sisters, etc.

	Like Child to do More Often	**Like Child to do Less Often**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

I confirm I have provided information to the best of my knowledge; I have read, understand, and agree to the above.

Signature: _____

Print Name: _____

Relationship to child: _____

Date; _____ (mm/dd/yy)

Thank you for taking the time to complete this form. Your openness is appreciated and will assist your treatment provider in developing a treatment plan best suited to your child's needs.

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PARENT(S) / GUARDIAN(S) INFORMED CONSENT

Your rights to information about us

All our mental health professionals are registered, certified, or licensed as required by law and are held to the highest of legal and ethical standards. We are committed to your rights of information regarding office policy, non-discrimination, confidentiality, consent, and competent service.

If you have any questions or concerns, please do not hesitate to tell us. For further information please visit our website www.wellnesscentre.ky or call us at 949-9355.

1. **Child Safety Policy**
   The Wellness Centre Ltd operates an open-door policy as it relates to the service of children under the age of 18 years. Although most therapeutic services are conducted behind closed doors between a child and their primary therapist, if at any time a parent wishes to do so, they may enter their child's therapy session without knocking or advanced notice.

2. **Confidentiality**
   Unless you grant us permission to do so in writing, we will not inform anyone that you are receiving therapy, nor will we disclose the content of your treatment. Additional consent will be required for The Wellness Centre to provide treatment to minors and to exchange information to a third party.

   Family matters will also require consent from all primary adults involved before treatment materials will be released. You may revoke your permissions in writing at any time.

   Please note client records will remain property of The Wellness Centre for a period of 10 years, after which time they will be destroyed. We function as a clinical team at the Wellness Centre and therefore utilize internal peer supervision and consultation regularly as well as professional external consultation and supervision as needed.

   Any para-professionals, administrators, or interns are also bound by our strict ethical code of confidentiality; they are bound by a written declaration of fidelity to confidentiality.

   However, there are few circumstances when we have a legal obligation to disclose information without your written permission:

   1) **Harm to a Child/Elderly Person/the Disabled**: If we are made aware that a vulnerable person is in direct danger, we are legally obligated to make our concerns known to the appropriate authorities;

   2) **Harm to Self or Others**: If at any time it is our clinical assessment that your actions or intentions are of a threatening nature to yourself or others, we have a legal obligation to make these concerns known to the appropriate authorities.

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3) **Order of the Court**. The Court of the Cayman Islands may at any time request information regarding your treatment where it is applicable to current or pending criminal case proceedings.

4) **Professional Supervision**. The Wellness Centre operates as a team structure and performs professional best practices such as clinical meetings, supervision, and consultations to ensure the most beneficial care in collaboration with internal practitioners. No outside professionals will be involved. Any conflicts of interest will be identified and may be avoided upon request.

3. Corporate Partners

All employees of our Corporate Partners receive individual, family, and couples counselling at no cost to them. Family members of employees may also receive free services or a Corporate Partner discount depending on the company. Corporate Partner employees also receive a discount for specialized services. Please identify yourself as an employee of one of our Corporate Partners at the time of booking.

4. Complaints

If at any time you believe your rights have been violated or you have concerns about the quality of service received, you are encouraged to speak to your therapist. If you are not able to resolve your concerns, you may contact the Director, Shannon Seymour, in writing.

Client Satisfaction Surveys are available at your request. If no course of action has been helpful to you, you have the right to speak to a member of the Health Practice Commission www.dhrs.ky/hpc/contact.php

The Cayman Islands Council for Professionals Allied with Medicine has set out a code of practice and guidelines for the provision of counselling services for your protection.

By signing below, you indicate you are fully informed and agree to the preceding information and consent to treatment. By signing below, you also agree that if you or someone in therapy with you makes an allegation against this agency, or any employee acting in the capacity of the agency for a legal or ethical violation we have the right to release information sufficient to our own defense against the charges made.

Signature of Client: _____

Print Name: _____

Date (dd/mm/yy): _____

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TheWellnessCentre

CONSENT FOR EXCHANGE OF INFORMATION FOR MINORS

CHILD'S FULL NAME: _____ DATE OF BIRTH: _____

I/We authorize ***The Wellness Centre Ltd.*** to RELEASE and/or OBTAIN information in regards to the social, familial, educational, behavioural, and psychological services of the above named child;

(☑ affirms ☒ deletes):

☐ TO/FROM: _____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

☐ TO/FROM: _____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

☐ TO/FROM: _____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

☐ TO/FROM: _____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

Information shared may include (☑ affirms ☒ denies):

☐ All clinical psychological and behavioural information – correspondence and documentation necessary for psychological treatment to be effective may be shared.

☐ Attendance information and correspondence regarding scheduling may be shared.

☐ Verbal reports on treatment progress and participation summaries may be shared.

Please list any special parameters or delimitations for this exchange: _____

_____

By completing this form I (We) acknowledge that I have legal parental responsibility or have otherwise been delegated legal guardianship/parental responsibility. By signing below, I (We) understand that consent shall remain valid for the duration of services at The Wellness Centre and not longer than 90 days from the date of the last contact. I have been informed that I may revoke this consent by written communication to The Wellness Centre at any time. I certify that this form has been fully explained to me and that I understand its contents.

_____

Guardian Name Signature Date (DD/MM/YY)

_____

Guardian Name Signature Date (DD/MM/YY)

_____

Witness Signature Date(DD/MM/YY)

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Client Financial Responsibility Agreement

Client Name: _____

Date of Birth: _____

The following is an explanation of The Wellness Centre's payment policy for all clients (including minors). It aims to minimize any misunderstanding about payment for services.

1. All invoices / receipts are presented in **Cayman Island Dollars**;
2. We accept cash, credit and debit cards for payment;
3. US$ cheques are accepted at the exchange rate of .82;
4. US$ cash, credit cards, and wire transfers are accepted at the exchange rate of 0.80;
5. Sessions may be suspended if your account is more than 30 days in arrears;
6. Your sessions may be terminated if your account is more than 90 days in arrears;
7. **The full-service fee will be charged for missed appointments;**
8. A missed appointment is one not cancelled PRIOR to 24 hours before the scheduled appointment time, or in the case of a Monday appointment, not cancelled by the corresponding appointment time of the preceding Friday. If the office is closed a voice mail message may be left on The Wellness Centre message system;
9. Cancellations made at the time of a scheduled appointment or after a scheduled appointment will be considered as a missed appointment;
10. If covered under a Corporate Wellness Contract, please note it does not cover missed appointment fees or late cancellation fees, the full fee will be charged directly to the client for all missed appointments;
11. Insurance companies will not pay for missed appointment fees or late cancellation fees;
12. The credit card held file will be charged for all amounts greater than 30 days old as per the credit card authorization form. If no credit card is held on file services must be paid pay in full at the time received;
13. Payment in full is expected at the time services are rendered if any of the following circumstances apply:
    a. You are a self-pay patient (you do not have insurance);
    b. You do not wish to have your insurance billed;
    c. You have not provided us all the current/correct information required to file an insurance claim including a current referral;
    d. Your insurance benefits do not cover the service(s) rendered.
14. If health insurance covers services in full or in part, the you will need to provide:
    - Insurance Card, Medical Referral and a form of photo ID;
15. It is your responsibility to confirm coverage with your insurance provider;

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16. The Wellness Centre will not be held responsible or liable for inaccurate information provided by the insurance provider;
17. You are responsible to inform The Wellness Centre of changes in your insurance before the time of service;
18. You are responsible for the full fee for services rendered but not covered by insurance;
19. At the time of service, you must pay co-pays, coinsurance, deductibles, and any services not covered by insurance;
20. You are responsible for obtaining and providing current referrals;
    a. Referrals are valid for 90 days;
    b. You are responsible for payment should the referral expire, and service(s) are provided during any period when a referral is not active;
    c. You are responsible for the balance of any claims not paid within 30 days;

The Wellness Centre reserves the right to charge interest and/or pursue delinquent accounts via third party collection agencies or attorneys at the client's cost.

The client expressly waives privileges concerning disclosure of all information necessary to proceed with collection activities and acknowledge an itemized account history, showing services rendered, fees charged, and payments received may be filed as an exhibit.

It is the client's financial responsibility for any additional services such as phone calls, letter writing, completion of forms, and administrative meetings in or out of the office. These services will be billed at the usual rate and will remain the client's obligation to pay.

The Client will notify The Wellness Centre immediately of any changes in the client's billing address / telephone and/or health insurance coverage.

This entire authorization is valid for all sessions and/or services rendered by The Wellness Centre. A copy of which may be used in place of the original.

The Wellness Centre and / or therapist(s) may release any information as necessary to process claims to a health insurance company.

I have read, understand, and agree to the above policies

Signature: _____

Date; _____ (mm/dd/yy)

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