**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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# CLIENT FINANCIAL AGREEMENT

| | | | |
|---|---|---|---|
| **Client Name** | | **Client Email** | |
| | | **Client Cell** | |
| **Parent/Guardian Name** | | **Parent Email** | |
| | | **Parent Cell** | |
| **Payment Method** | Time of Service Advance Self-Pay Monthly Self-Pay Insurance /co-pay | | |
| **Insurance Details** | Insurance Company: | | |
| | Primary Policy Holder | | |
| | Group Number | | |
| | Client Policy Number | | |

**DIRECT DEPOSIT / ELECTRONIC FUND TRANSFER:** When making an online or direct deposit please ensure the CLIENT name is noted in the narration/memo so that the deposit can be accurately applied to account.

**Bank**: Cayman National **Branch**: Elgin Avenue
**Name**: The Wellness Centre **Type**: KYD Chequing
**Account#**: 011-09070

**CREDIT CARD AUTHORIZATION:** To have The Wellness Centre charge a credit/debit card for service fees complete the information below and return by hand directly to the Billing Administrator.

| | | | |
|---|---|---|---|
| **Client Name** | | | |
| **Cardholder Name** | | | |
| **Card Number** | | | |
| **Expiry Date** | | **CCV** | |
| **Card Type** | ☐ Visa<br>☐ Mastercard | **Currency** | ☐ KYD<br>☐ USD |

**AUTHORIZATION:** I hereby authorize The Wellness Centre Ltd to charge the credit/debit card listed above for the following: **select one**

- ☐ SELF-PAY | Fees for services on date of appointment (courtesy discount applied)
- ☐ SELF–PAY | Invoiced Monthly fees
- ☐ Insurance Co-Pay charged on date of service, insurance claim to be submitted by The Wellness Centre.
- ☐ SELF-PAY | PAYMENT PLAN: Overdue balance as of _____ day of _____, 20___ is KYD$_____. _____ payments of KYD$_____ will be applied on the 1st day of each month ending _____ day of _____, 20___.

**FINANCIAL RESPONSIBILITY**

- ☐ I accept full responsibility for all costs associated with services outlined herein received from The Wellness Centre.
- ☐ If paying by **credit card**; I accept the responsibility to update The Wellness Centre if card details change.

- ☐ If paying by **direct bank transfer**; I accept responsibility to ensure transactions are made accurately and in a timely manner to ensure deadlines of receipt of funds.
- ☐ With acceptance of **insurance coverage**, I understand The Wellness Centre may verify my coverage as a courtesy; but The Wellness Centre cannot be held responsible or liable for inaccurate information provided by my insurance provider.
  - ☐ I accept responsibility to confirm coverage with my insurance provider and communicate to The Wellness Centre any changes in my insurance coverage or policy immediately so that claims can be filed within the insurance providers deadlines. I accept responsibility for the full fee for services rendered but not covered by my insurance carrier.
  - ☐ I understand co-pays, coinsurance, deductibles, and any services not covered by my insurance plan must be paid at time of service.
  - ☐ I am responsible for obtaining and providing any required medical referrals. It is my responsibility to meet the referral requirements of my insurance provider.
  - ☐ Should my referral expire and service(s) are provided during any period when a referral is not active, I am responsible for payment.
  - ☐ Insurance companies will not pay for missed appointment fees or late cancellation fees, I accept responsibility for these fees.
  - ☐ I am responsible for the balance of any insurance claims not paid within 30 days.

**NAME FINANCIALLY RESPONSIBLE PERSON**_____

**SIGNATURE**: _____

Dated the _____ day of _____, 20_____.

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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