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: _____

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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

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: _____

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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.?

_____

_____

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?

_____

_____

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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:

_____

_____

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):

_____

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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) _____

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	_____

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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:

- ☐ 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

_____

_____

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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 night
- Trouble waking up
- Fatigue/tiredness during the day
- Nightmares
- Bed wetting
- 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
- Soiling
- Problems with authority
- Anxiety/Worry
- Unmotivated

Please explain all items endorsed_____

_____

_____

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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.

Guardian Signature: _____

Print Name: _____

Date (dd/mm/yy): _____

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Client Financial Responsibility Agreement

The following document explains The Wellness Centre's payment policy and financial responsibility for all clients (including minors). It aims to minimize any misunderstanding about payment for services.

Client Name		**Client Email**	
		Client Cell	
Parent/Guardian Name (if Under18)		**Parent Email**	
		Parent Cell	
Payment Method	Self-Pay | Health Insurance | Corporate Wellness Benefit		
Insurance Details	Insurance Company:		
	Primary Policy Holder		
	Group Number		
	Client Policy Number		

FINANCIAL RESPONSIBILITY

- I accept full responsibility for all costs associated with the services I receive from The Wellness Centre.
- I accept that I may utilize my health insurance coverage and that The Wellness Centre may verify my coverage as a courtesy however, The Wellness Centre cannot be held responsible or liable for inaccurate information provided by myself or 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 provider's deadlines.
- I accept responsibility for the full fee(s) for services rendered but not covered by my insurance provider.
- I accept that any co-pay, coinsurance, deductible, and / or service not covered by my insurance plan must be paid at time of service.
- I accept that The Wellness Centre and / or therapist(s) may release any information as necessary to process claims to my health insurance company.
- I accept that I am responsible for obtaining and providing any required medical referrals. It is my responsibility to meet the referral requirements of my insurance provider.
- I accept full responsibility for the payment due on services that are provided during any period when a referral is not active and / or expired.
- I accept full responsibility for the fees associated with missed appointments and / or late cancellations. (**The full-service fee will be charged for no show appointments, and a partial payment will be charged for appointments cancelled with late notice less than 24hrs)**.

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- I accept that no Corporate Wellness Contract or health insurance plan can be utilized to cover the fees associated with missed or late cancellations.
- I accept full 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.
- I accept the responsibility to immediately update The Wellness Centre of any changes to the credit / debit card associated with my payments.
- I accept the responsibility to immediately update The Wellness Centre of any changes of physical / billing address and contact information.
- I accept the responsibility to ensure that any **direct bank transfers** are made accurately and in a timely manner, to ensure The Wellness Centre is in receipt of funds on their respected due date.
- I accept that 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.
- I accept that I am expressly waiving 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.
- I accept that this Financial Responsibility Agreement 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 agreement signed.

All invoices / receipts are presented in **Cayman Islands Dollars** and payments by USD cash, credit / debit cards, and wire transfers are accepted at the exchange rate of 0.80. **Services may be suspended if your account is more than 30 days in arrears.**

PAYMENT DETAILS

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 Bank | **Branch**: Elgin Avenue
Account Name: The Wellness Centre Ltd.
Account Type: KYD Chequing
Account Number: 011-09070

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CREDIT CARD AUTHORIZATION: I authorize The Wellness Centre to charge a credit/debit card for service fees delivered.

Client Name			
Cardholder Name			
Card Number			
Expiry Date		**CCV**	
Card Type	☐ Visa ☐ Mastercard	**Currency**	☐ KYD ☐ USD

I have read, understand, and my signature below indicates my agreement with the above policies.

Print Name	
Signature	
Date	

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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**:**

☐ 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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