**Barbara Price Roth, MS, LCPC, LLC**

***Licensed Clinical Professional Counselor***

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 **rothbp@gmail.com**

Welcome to my practice. In order to assist me in providing you with quality services, inform you fully and facilitate insurance reimbursement, please complete this form, read the attached *Patient Rights and Responsibilities*, and sign where indicated. Thank you.

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child Client Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_

Gender [male] [female] [other]

School attending \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address used for Insurance: Parent/Guardian at this address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP \_\_\_\_\_\_\_

Home Ph. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Persons in primary household**: Name & age, also include P/T family and pets

**Losses or family changes within past 2 years**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Trauma – victim of physical / emotional / neglect/ environmental/ other**

**What is the main reason you are seeking treatment?**

**When did the problem start and what did you notice?**

**What would you most like to accomplish in treatment?**

**Please check ALL that apply to you at this present time:**

**Increased Crying**

**Nightmares**

**Poor Concentration**

**Easily Startled**

**Phobias**

**Irritability**

**Anger**

**Hallucinations**

**Chest Discomfort**

**Feelings of Guilt**

**Dizziness**

**Suspicions**

**Excessive Sweating**

**Hypervigilance** (excessive attention

to things around me)

**Lack of Motivation**

**Fear of Social**

**Performance**

**Avoidance of Places, People or things**

**Sad Mood**

**Poor Sleep**

**Sad Affect**

**Racing Thoughts**

**Low Energy**

**Anxiety in Public Places**

**Impulsiveness**

**Loss of interest in things once enjoyed**

**Memory Problems**

**Abused Physically, emotionally or sexually**

**Restlessness**

**Obsessions/Compulsions** (constant checking, washing or worries)

**Weight Changes**

**Decreased Self Esteem**

**Stomach Problems**

**Rapid Heartbeat**

**Intense Fear**

**Eating Problems**

 explain:

Please add additional behavioral observations, school concerns, teacher or coach

observations, and / or concerns of your child:

**Please complete the Attachment and Trauma Assessment and any other Assessment suggested at this time by Ms. Roth**

**Thank you**

**Wellness Information (Child - under 12)**

**What activities or sports do you enjoy?**

**Have you been dieting to lose weight? \_\_\_\_ Amt. of weight gain or loss in the past 3 months\_\_\_\_**

**How well are you sleeping? Number of hours avg.**

**Please list other wellness activities or pursuits that you enjoy ?**

Strengths & Personal Assets –

 **Suicide Risk Assessment**

**Have you ever had thoughts of harming yourself?** [yes] [no]

**If YES, please answer the questions below. If NO, please skip this section.**

**Do you currently want to harm yourself?** [yes] [no]

**How often do you have these thoughts?**

**When is the last time you remember having these thoughts?**

**Have you devised a plan on how you would harm self?** [yes] [no]

**Is there anything that would prevent you from harming yourself?** [yes] [no]

If yes, please explain:

**Medical Information**

Primary Care Provider for Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location & Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to communicate with this person is (please initial): Authorized\_\_\_\_ Withheld \_\_\_\_

Medical conditions or concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past 6 mo., how many times did you visit a medical provider? None\_\_ 1\_\_\_ 2-4\_\_ 5+\_\_\_

Please list client’s OTC & Prescription medications and supplements

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other current Medical Providers or Behavioral Health Supports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Behavioral Health or Psychiatric History: therapist names and dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Hospitalization for Assessment, Treatment or ER visits for any reason or Subs. Abuse (dates)

Date:\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If none then: \_\_\_\_\_\_ [initial] I have had no previous psychiatric or psychological treatment

**Family history** **of Depression/ Anxiety or Other Psychiatric Condition** – relationship to client:

**Personal & family history** related to: Social- home, friends, work, neighborhood; Legal problems, Educational or Health challenges not already mentioned:

**Are firearms in the home?** [yes] [No] If so, how many & what type:

*I affirm that the above information is correct and complete and that I have read and understand the attached* ***Patient Rights and Responsibilities****. I understand that I am responsible for sessions canceled with less than 24 hours notice and for any portion of my bill not covered by insurance for any reason. I have been advised that psychotherapy carries both risks and benefits and my signature below constitutes my informed consent to share confidential information with my insurance company or other third party payer and any outside billing representative.*

*Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_*