LIFEPULSE CENTER™
for Development & Growth
Faith Nouri, PhD, LPC

NEW CLIENT INFORMATION SHEET - Child

Today's Date: _____

Name (print): _____ **Gender:** _____ _____
(Last) (First) (Middle) (male) (female)

Soc. Sec. No.:___ ___ ___ - ___ ___ -___ ___ ___ ___

Date of Birth: ___-___-___ **Age:** ____

Mother: _____ **Father:** _____

E-mail Address (Mother): _____

Mother's Cell Phone: _____

Email Address (Father): _____

Father's Cell Phone: _____

Referral Source: _____

Home Address: _____ **Home Phone:** _____

_____ **Cell Phone:** _____

_____

Mother's Name: _____ **Phone #:** _____

Father's Name: _____ **Phone #:** _____

Parents are: ____ **Married** _____ **Divorced** ____ **Separated**

Emergency Contact: _____

Emergency Contact Number: _____

- Considering issues that may come up during the session where access to a parent may be necessary, it is required for parents to wait in the waiting room while their children are in the session.

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Child/Adolescent Background Information *(use for all minors)*

Welcome to my office. Please answer all information as completely as possible. If applicable, both mother and father should complete together. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. I will discuss your responses with you after I have reviewed the form.

Thank You,
Dr. Nouri

Completed by: _____*Relationship to Child:* _____

Child's Address:

_____
Street City State Zip

Child's Gender: Male__ Female__ *Date of Birth*__ / / __ *Age* *SS#*

Child's Ethnicity:
Africa American___ Bi-racial___ Hispanic/Latin___
Asian___ Caucasian___ Native American___ Other _____

Child's primary language: English ___ Spanish ___ Other _____
Language spoken at home---- (parent's language) _____

Child's Legal Guardian (Managing Conservator)*:* _____
(If the child is not living with both natural parents, both adoptive parents, or only living parent, the clinic requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page). (The photocopy should be stapled to this form.)

Is your child presently receiving counseling elsewhere? Yes No
(If yes, do not complete this form until you have talked with your counselor)

School Child attends:
Current School Address & Phone _____
*Grade Level (*now): _____ *Has your child ever been retained? Yes No If yes, what grade* _____
*Current Teacher(s): 1)*_____ *2)*_____ *3)*_____
Current School Counselor:

*Is your child receiving special education or other services? Yes No (explain)*_____

Has your child ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No
(If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency_____
Name: _____

Address: _____

Phone_____ Dates of Service_____(beginning - ending)

Has your child been hospitalized for mental health concerns? Yes No
If yes: When _____ Where_____

* INFORMATION ON CHILD'S MOTHER *

Mother's Name: _____
Last ***First*** ***MI***

I am: biological mother stepmother adopted mother Other

Address: _____
Street ***City*** ***State*** ***Zip***

Date of Birth: _____ *Occupation:* _____
Employer *How Long:*

Last Year of education completed:

8th grade or below _____	Trade School ___	Master's Degree ___
High School ___	Some College ___	Ph. D. Degree ____
GED ___	College Graduate ___	

History of learning, emotional, or behavioral problems: Yes No
(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes please explain) _____

Current living arrangements:

Family of origin___	Relatives___	Single___
Married___	Roommate(s)___	Single parent w/children___
Married w/children___	Significant other___	Other_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985):
Never married ___
Married 1_____ Separated 1_____ Divorced 1_____ Widowed 1_____

Married 2_____ Separated 2_____ Divorced 2_____ Widowed 2_____
Married 3_____ Separated 3_____ Divorced 3_____ Widowed 3_____

* INFORMATION ON CHILD'S FATHER *

Father's Name: _____
Last *First* *M.*

I am *biological father* *stepfather* *adopted father* *other*

Address: _____
Street ***City*** ***State*** ***Zip***

Date of Birth: _____ *Occupation:* _____
Employer: _____ *How long:* _____

Last Year of education completed:
8th grade or below _____ Trade School ___ Master's Degree ___
High School ___ Some College ___ Ph. D. Degree ____
GED ___ College Graduate ___

History of learning, emotional, or behavioral problems: Yes No
(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes please explain) _____

Current living arrangements:
Family of origin___ Relatives___ Single___
Married___ Roommate(s)___ Single parent w/children___
Married w/children___ Significant other___ Other_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____
Married 1_____ Separated 1_____ Divorced 1_____ Widowed 1_____
Married 2_____ Separated 2_____ Divorced 2_____ Widowed 2_____
Married 3_____ Separated 3_____ Divorced 3_____ Widowed 3_____

* GENERAL INFORMATION *

Child's current household:
Adoptive parents ___
Blended family (both spouses with children) ___ Natural Father and Stepmother ___

Father only ___ Natural Mother and Stepfather ___

Foster family ___ Natural Parents ___
Institution___ Relatives ___
Mother only ___ Other_____

List by Household your child's current family, beginning with the oldest member and include the child:
Primary Household (anyone who currently lives with child)
How long in this current living situation: _____

Name	Age	Gender	Relationship to you (include step, half, etc.)

Child lives in: House_____ Apartment _____ Duplex _____ Other_____

Second Household (non-custodial or extended family - if applicable)

Name	Age	Gender	Relationship to you (include step, half, etc.)

Currently involved in a custody dispute: No Yes (If yes, explain) _____
_____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly
1 -- 2 3 4 5

How often does client see non-custodial parent? _____

**** CHILD'S HEALTH ****

Child's Primary Care Physician: _____
Name Phone

Address

Has your child ever seen a psychiatrist? Yes No

Is child currently seeing a psychiatrist? Yes No (If yes, list name, address and phone):

_____

Name Phone

_____

Address

*Date of LAST complete physical*_____
Physical Disability: Yes No (If yes, explain) _____
Chronic Illness: Yes No (If yes, explain) __
Terminal Illness: Yes No (If yes, explain)_____
Check the following items for a diagnosis or medication that your child is now receiving or has received:

Diagnosis	**Current**	**Past**	**Date of Diagnosis**	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/					

Sleeplessness _____ _____ _____ _____ _____

Obsessive/
Compulsive _____ _____ _____ _____ _____

Addictions _____ _____ _____ _____ _____

Convulsions _____ _____ _____ _____ _____

Post-Traumatic
Stress Disorder _____ _____ _____ _____ _____

Other _____ _____ _____ _____ _____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If your child has been diagnosed, who gave the diagnosis?
Counselor/Psychologist___ Family Physician___ Psychiatrist___ School___
Other_____
Name: _____ Phone #: _____

What other medication is your child currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

**** CURRENT CONCERNS ****

Indicate severity of up to 10 items that currently apply to your child. (1-mild; 2-moderate; 3-severe)
Circle the item that you see as the most significant issue)

___Abuse (physical, emotional, sexual)
___Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, aging, etc.)
___Bed wetting daytime wetting, soiling or related problems
___Career Decisions
___Disturbing memories (past abuse, neglect or other traumatic experience)
___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Family or Stepfamily relationship problems
___Feeling angry or irritable
___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
___Feeling guilty or shameful
___Feeling sadness or depression NOT related to grief
___Feeling sadness or depression related to grief
___Gang related concerns (explain)_____

___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
___Learning/Academic difficulties
___Non-family relationship problems (teachers, peers, etc.)
___Parent-Child relationship (discipline, adoption, single parent, etc.)
___Personal Growth (no specific problem)
___Religious or Spiritual concerns
___Sexual concerns (excessive masturbation, inappropriate acting out)
___Sexual identity concern
___Sleep problem (nightmares, sleeping too much or too little, etc.)
___Speech problem (not talking, stuttering, etc.)
___Suicidal Ideation (thoughts of death, wanting to die)
___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Other (explain)_____

Remember to circle the most significant issue.

When did you first become concerned about this issue? _____
How have you attempted before now to deal with this issue?
_____

Other treatment your child has received to address any of the concerns indicated above: None___
Couples Counseling___ Group counseling___ Individual counseling___
Family counseling___ Hospitalization___ Other _____

What do you enjoy most about this child? _____

What do you find most difficult about this child? _____

*Anything else you think we need to know*_____

What is the one thing I need to know to help your child today? _____

* FAMILY HISTORY/EXPERIENCES *

(For each of the following items that apply, write in your child's approximate age at the time it occurred):

Raised by:
Adoptive parent(s)___ Institution___ Relatives___
Foster parents___ Natural parents___ Single natural parent___
Grandparents___ Natural and step-parent___ Other_____

Stressors in the Family:
Chronic illness of family member___ Death of significant person___ Domestic Violence____

Family member absent (explain)_____
Family member's disability/major accident/illness___
Family member emotional problems (explain)_____
Family member suicide (explain)_____
Financial problems___ Moved a lot___ Parents arguing frequently___ Parents divorced___

Other _____

History of your child having learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____

History of your child having alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____

History of criminal activity in the family: Yes No
(If yes, please explain) _____

Has your child been abused (check all that apply): Physically___ Emotionally___ Sexually___

Has your child been neglected (check all that apply): Physically___ Emotionally___

School Problems (check all that apply):
Academic problems___ Discipline problems___ Severely teased___ Unpopular___
Other _____

Early Language/Speech Problems (explain)_____

History of emotional concerns include:
Appetite change ___ Heard voices___ Suicidal thoughts___
Emotional problems___ Loss of energy or fatigue___ Suicide attempts___
Gained weight ___ Lost weight___ Other _____

History of behavior problems includes: (check all that apply):
Accident-prone___ Aggressive Behavior
(explain)_____
Alcohol/drug use___ Attention problems___ Frequent arguments___ Hyperactive___
Impulsive___ Loner___ Misbehaved a lot___ Ran away___

Taken advantage of___ Temper outbursts___ Trouble with the law___
Other_____

History of anxiety symptoms includes: (indicate all that apply):
Irritable ___ Obsessive worrying ___ Physical symptoms (below) ___
Keyed up, on edge ___ Phobias ___ Other _____

History of health/physical problems includes: (check all that apply):
Asthma___ Disability___ Nervous stomach ___
Bedwetting___ Dizziness ___ Neurological problems/exam___
Bone/joint/muscle ___ Headache (kind) ___ PMS ___
Chest pain ___ Heart Palpitations___ Serious overeating/undereating__

Chronic illness___ Hospitalization___ Shortness of breath without exertion ___
Developmental delay(s)___ Major accident___ Sleep problem___
Diarrhea ___ Major illness___ Surgeries___
Other_____

History of trauma/stressor includes: (check all that apply):
Child separated from parent (how long and when)_____
Death of a pet___ Death of a significant person___ Incarcerated family member___
Medical___ Natural Disaster___ Sexual Assault___
Victim of trauma (unusual, terrifying experience)___ Other_____

History of interpersonal problems includes: (check all that apply):
Aggressive behavior (explain)_____ _____
Bullied___ Taken advantage of___
Frequent arguments___ Temper outbursts__
Loner___ Other_____

Family Atmosphere (circle the number that best describes how you view your child's current family atmosphere)

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

Family Support System (such as church, friends, relatives, school)

Hardly any support	1	2	3	4	5	Considerable support

Your child's current use of Computer, VCR, and Television (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV/VCR (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

Services at LifePulse Center include, but are not limited to, individual therapy, group therapy, parenting consultations, and corporate consultations, as well as play and activity therapy for children and adolescents. Individual sessions are 45-50 minutes. Psychotherapy is a process and weekly sessions are recommended for the first 8 to 12 sessions for continuous progress and change.

I have read and understand the above statement. I also understand that I will be charged $130 for a 45-50 minute session and agree to pay this amount at the time of each session unless we make other arrangements for insurance reimbursement. I further understand that **I am responsible** for a $60 fee for sessions canceled within less than 24 hours of my scheduled appointment time. In case of a need for a phone consultation, if the conversation lasts more than 10 minutes, I am responsible for a payment of $65 for the first 30 minutes and $130 for a 45 minute consultation.

Signature: _____

Date: _____

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Child's Name: _____ **Date:** _____

Person completing this form: _____

Please identify your concerns about this child by placing a number beside a problem, using the choices below. Only rate items when you have a concern. Do not place numbers next to problems about which you have no concerns.

8 = Slight concern but I have *not* thought about getting help for this problem
7 = Some concern *or* I have thought about getting help for this problem
6 = Moderate concern *or* someone has encouraged me to get help for this problem
5 = Serious concern *or* a few people have encouraged me to get help for this problem
4 = Major concern *or* many people have pressured me to get help for this problem
3 = Unable to function *or* the child is totally unable to do what is age-appropriate in this area
2 = A danger to self or others some of the time
1 = A persistent danger to self or others

_____ Abuse or Neglect of Child
_____Acts without Thinking (Hyperactive or Impulsive)
_____Aggressive Behavior
_____Anger
_____Anxious, Tense, Worried
_____Arguing with Adults
_____Arguing with Other Children
_____Arithmetic
_____Articulation, Spoken Language
_____Bad Dreams or Nightmares
_____Bedwetting
_____Bothered by Recurring Thoughts
_____Bothered by Some Trauma
_____Bullying or Threatening Others
_____Classroom Behavior
_____Complains about Not Feeling Well
_____Coordination
_____Critical of Self
_____Daydreaming
_____Defiant, Oppositional, Noncompliant
_____Destruction of Property
_____Divorce of Parents
_____Eating
_____Fears or Phobias
_____Fidgeting, Squirming, "Hyper"
_____Fighting
_____Fire Setting
_____Grief or Bereavement
_____Health Problems
_____Homework
_____Impact of Child's Problems on Parents
_____Impact of Child's Problems on Siblings
_____Irritable
_____Lying
_____Makes Strange Vocal Sounds
_____Makes Strange, Jerking Movements
_____Making or Keeping Friends
_____Parent–Child Relationship
_____Paying Attention
_____Performing Unusual Habits or Rituals
_____Playground Behavior
_____Playing or Relating with Other Children
_____Reading
_____Refusing to Speak
_____Relationship with Sibling(s)
_____Sadness/Depression
_____School Attendance
_____School Grades
_____Self-Injurious Behavior
_____Sexual Behavior
_____Shy
_____Sleeping
_____Social Skills and Problem Solving
_____Soiling Underwear
_____Stealing
_____Strange, Weird, or Peculiar Behavior
_____Tantrums
_____Teased or Victimized by Peers
_____Weight
_____Worrying about Being Separated from a Parent
_____Writing
_____Other: _____
_____Other: _____
_____Other: _____

Faith M. Nouri, Ph.D.
Licensed Professional Counselor
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972-992-3992

PROFESSIONAL DISCLOSURE STATEMENT

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicated. Together we will work to achieve the best possible results for you.

Client Rights: Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time though I do ask you participate in termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know and I will address your concerns. If I am not able to resolve your concerns, you may report your complaints to the Texas LPC Board at 1-800-942-5540.

Postponement and Termination: I reserve the right to postpone and/or terminate counseling of clients who come to their session under the influence of alcohol or drugs. I also reserve the right to discontinue counseling of clients who do not comply with the medication recommendations of their psychiatrist or physician.

Cancellation: In the event that you will not be able to keep an appointment, please notify me at least **24 hours in advance**. I reserve your scheduled appointment only for you; therefore, your failure to cancel appointments 24 hours in advance does not allow me to offer your time slot to other clients requesting time. As a result, **YOU ARE RESPONSIBLE FOR $60 PAYMENT FOR THE MISSED SESSION.** In the case that fee for the sessions is covered by an Employee Assistance Program, please note **you – NOT THE INSURANCE PROVIDER – are responsible for the $60 payment of the missed session.**

Fees: In return for a fee of $130 per session, I agree to provide counseling services for you. The fee for each session will be due and must be paid at the conclusion of each session. Credit card, cash or personal checks made out to "Dr. Nouri" are acceptable for payment. I only file for reimbursement from a few health insurance companies. However, I will provide you with a receipt for services that you can file with your insurance company for out-of-network benefits. Let me know if you have questions about the insurance companies I work with.

Counseling Relationship: During the time we work together, we will meet weekly for approximately **45 minute** sessions. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns.

Records and Confidentiality: All of our communication becomes part of the clinical record. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: 1) I determine that you are a danger to yourself or someone else; 2) you disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; 3) you disclose sexual contact with another mental health professional; 4) I am ordered by a court to disclose information; 5) you direct me to release your records; or 6) I am otherwise required by law to disclose information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge any secret to be detrimental to the therapeutic progress.

By your signature below, you are indicating that you read and understood this statement, or that any questions you had about this statement were answered to your satisfaction, and that you were furnished a copy of this statement By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

_____
Client's Name

_____ _____
Client's Signature (Parent or Guardian) Counselor's Signature

_____ _____
Date Date

HIPPA, Emails, Texts, Audio/Video (Skype or other forms of communication):
I have been informed and am aware of HIPPA regulations.
I recognize that online and mobile communication is not confidential. I give permission to LifePulse Center™ and/or Dr. Nouri to communicate with me through the above means of communication as needed.

_____
Client's Signature (or Parent or Guardian)