Beautiful Autism, LLC

CLIENT INFORMATION SHEET
Child/Adolescent

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law.

Personal Information:		
Name:	Sex: M ❑ F ❑	Birth Date: Age:
Street:		
City:	State:	Zip Code:
Mother's First/Last Name:	Mother's Cell #:	Ok to Text? Y / N
Mothers Email:		
Father's First/Last Name:	Father's Cell #:	Ok to Text? Y / N
Fathers Email:		
Guardian's First/Last Name:	Guardian's Cell#	Ok to Text? Y / N
Guardian's Relation to Child:	Guardian's Email:	
Home #:	Work#	Other#
May your therapist leave a message for you at home/Cell? Yes ❑ No ❑		
Best Contact Method:		
Religion:	Race:	Languages:
School:	IEP: Yes ❑ No ❑	Grade:
In case of an emergency contact:		Phone# :
Relation to Patient:		
How can we help you?		
Please state the nature of the client's problem, and what you would like to accomplish through counseling:		
How serious does this problem feel to you? 1 2 3 4 5 Mildly upsetting ⟷ Extremely serious		

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For our Records:
How did you hear about us?
Would you like to receive updates regarding Beautiful Autism via e-mail? Yes ❑ No ❑

Social Interaction/Behavior:
Describe social interaction the client has:
Has any teacher, doctor, or therapist commented on lack of social appropriateness? Yes ❑ No ❑ Has any teacher, doctor, or therapist commented on challenging behavior? Yes ❑ No ❑
Describe any challenging behaviors:

Social Skills:

Check any social skills that your child struggles or has difficulties with:

___ Difficulty meeting and making friends
___ Difficulty keeping friends
___ Friends tend to be older or younger, not the same age
___ Difficulty being assertive
___ Being overly assertive
___ Poor self-esteem
___ Trouble with stress management
___ Trouble with anger management
___ Difficulty initiating and maintaining appropriate communication
___ Difficulty with voice modulation and pragmatics (using and understanding language within social contexts)
___ Exhibits socially unacceptable behaviors
___ Difficulty picking up nonverbal social cues
___ Struggles with power control (wants to always be in control of things)

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Family Status:
Who has custody of the client?
Is there a custody agreement? Yes ❑ No ❑ Date of next custody hearing: Is there a restraining order? If yes, against who?
Siblings names and ages:
Describe relationship with extended family:
Other children living with client? Names, Ages & Relationship to client:
Other adults living with client:
Family History:
Father's age: Occupation: Mother's age: Occupation:
Did the client grow up with both parents in the home? Yes ❑ No ❑ If no whom did/does child reside with full time? Does Non-Custodial Parent have residential time?
Are parents married/together? Yes ❑ No ❑ If No date of Separation/divorce:
Whom does the client feel closest to? Mother ❑ Father ❑ Neither ❑
Briefly describe the relationship with Father:
Briefly describe the relationship with Mother:
Please explain if any member of your family has ever suffered from anything that could be described as an "emotional" or "psychological" problem (i.e. depression, suicide…):

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Family History Continued:
Please explain any abuse (physical, sexual, or psychological) the child has had:
Please mention any history of domestic violence, child abuse or sexual abuse in your family:
Please explain any history of alcohol or drug use the child has had:
Please comment on any history of alcohol or drug use in your family:
Has the client been diagnosed with any mental illness? (Depression, Anxiety, Autism, ADHD, etc.):
Family History of Mental Illness?
Has the child been arrested? Yes ❑ No ❑ Has anyone in the family been arrested? Yes ❑ No ❑ If yes, please explain: If yes please explain:

Medical History:				
Please indicate with an "x" to what degree the client may or may not suffer from the following:				
	Never	**Seldom**	**Sometimes**	**Often**
Alcohol intake	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Back pain	❑	❑	❑	❑
Caffeine consumption	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Depression	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑

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Medical History Continued:				
Ear infections	❑	❑	❑	❑
Eating disorder	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
General illness (cold, etc.)	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Insomnia	❑	❑	❑	❑
Loss of appetite	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Phobias(fears)	❑	❑	❑	❑
Smoking	❑	❑	❑	❑
Suicidal thoughts	❑	❑	❑	❑
Please explain any concerns with boxes marked "often":				
Current weight: One year ago: Maximum: When:				
Does the client exercise regularly? Yes ❑ No ❑ How?				
Does the client sleep well? Amount (hours): Easy to get to sleep? Yes ❑ No ❑ Describe sleep patterns:				
What recreation/Activities does client enjoy?				
Females- Has menstrual cycle begun? Yes ❑ No ❑ Do things appear to be going medically typical for menstrual cycle? Yes ❑ No ❑				

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Medication History:

Please indicate with an "x" how often your child uses any of the following:

	Never	Occasionally	Frequently	Daily
Appetite suppressants	❑	❑	❑	❑
Aspirin/Tylenol	❑	❑	❑	❑
Blood pressure medicine	❑	❑	❑	❑
Drug use (street drugs)	❑	❑	❑	❑
Sedatives/tranquilizers	❑	❑	❑	❑
Sleeping pills	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑
Other :	❑	❑	❑	❑

Please list all current medications:

Have your child seen a mental health therapist before? If yes, when?

Yes ❑ No ❑

Length of therapy: Was therapy successful? Yes ❑ No ❑

Please comment:

Has client ever been hospitalized for psychiatric reasons? Yes ❑ No ❑ If yes, when?

Facility Name: Brief Reason why:

Length of hospital stay:

Any medical hospitalizations? (besides birth) Yes ❑ No ❑

If yes, please describe and give dates:

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Current and Past Care Providers:	
Primary Care Physician Clinic Name/Location:	Date of last physical:
Psychiatrist Name Clinic Name/Location:	Med Management Yes ❑ No ❑
Any medical conditions/concerns:	
Any type of therapist: If so, where?	
The hardest time in development was:	Toddler ❑ Preschool ❑ Kindergarden ❑ Grade School: ❑ Middle School ❑ Highschool ❑
Has client ever attempted suicide? Yes ❑ No ❑	Preschool ❑ Grade school ❑ Junior high ❑ High school ❑ Now ❑
Explain the prenatal history, delivery, and infancy. Were there any medical issues, complications, medications by mother or baby, early deliver, etc.?	If Yes, How many times? Date(s):
Explain the toddler and preschool years, including milestones such as walking, talking, speech, toileting, etc.	

Name of Insurance Company:		
Insurance ID #:	Group #:	
Subscribers Name:	Subscribers Birth Date:	Employer:
Subscriber Address if Different:		
Secondary insurance:	Insurance ID#	
PLEASE PROVIED INSURANCE CARDS FOR SCANNING		

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Attendance Agreement

Attendance is very important for effective therapy. Therapy is generally once a week, or twice a month, based on the client's particular needs which will be determined by the therapist. Things such as late arrivals, missed appointments, late changes, and cancellations can and likely will impact the therapeutic process. Because of that, the following will be placed into effect as of August 1, 2018:

- 3 missed appointments, meaning no show and no cancellation, will lead to a cancellation of services.
- Any missed appointment will also be charged a $50 no show fee. This fee cannot be billed to insurance and is expected to be paid in full before the next session.
- If client arrives 15 minutes late for appointment, you may not be able to be seen and will be charged a no-show fee of $50.
- All late changes, including rescheduling and canceling, (within 24 hours of session) will be charged $50.
- All clients will be given 5 excused missed sessions a calendar year. These can be used for travel, other appointments, family engagements, illness, etc. As long as appropriate time is given for cancellation (more than 24 hours), no fee will be charged. After 5 missed sessions, a $50 fee will be charged for any cancelled session, even if more than 24 hours notice is given. This fee cannot be billed to insurance; the family is expected to pay this fee and needs to be paid before the next session. Rescheduling with the therapist to avoid missing sessions towards the 5 excused missed sessions can be looked into at the discretion of the therapist and according to their availability.
- Illness can happen at any time; we certainly appreciate clients not coming in when they are sick. If the client is feeling sick the day before the session, please call and let us know; you will not be charged the late fee even if it is within the 24 hours. If you call to let us know, but the client is well enough the following day, the client is more than welcome to come in for session. Please note that illness from a parent or sibling is not a reason to cancel for the client; Please seek alternative arrangements for the client to come for therapy. If a late cancellation needs to happen due to illness, it will go towards the 5 excused missed sessions per calendar year. The $50 late cancellation fee will not be charged for illness unless the 5 excused missed sessions have been used already.
- The 5 excused sessions are for each different therapy and/or each day. For example, if you see a behavior tech two days a week, you have 5 excused sessions for each day.

Name of client _____ Date _____

Signature of client (guardian) _____

Print Name _____