Sunrise Counseling

Christine Burrell Townsend, LCSW, ACSW (License #002958)
2386 Clower St. Bldg C-100
Snellville, GA 30078
770 985 2050

I look forward to working with your child/family. Although I cannot guarantee any specific results, we will work together to resolve the issues that have lead you to seek my help and support. The nature of counseling is very personal; therefore we will maintain a professional relationship consistent with accepted ethical standards. All clients/families are in complete control and may end our professional relationship at any time.

The forms in this packet will help you to provide me with information so that I can be of greater assistance to your family. It will also give you a better understand of my practice and policies. Please fill out this biographical background form as completely as possible. It will help me in your child's treatment. All information is confidential as outlined in the informed consent form.

Today's Date_____

Name of Child:_____ Date of Birth:_____ Age_____

Current School:_____

Child lives with: Mother Father Both Parents Guardian

Who has legal custody? Mother Father Both Parents Guardian

Mother's Name: _____ Date of Birth: _____

Address: _____City: _____Zip: _____

Telephone: H: _____W: _____Cell: _____

May I leave a message? If so, on which number? _____

E-mail: _____ May I e-mail you? _____

Mother's Employer:_____ Job Title:_____

Father's Name: _____ Date of Birth: _____

Address: _____City: _____Zip: _____

Telephone: H: _____W: _____Cell: _____

May I leave a message? If so, on which number? _____

E-mail: _____ May I e-mail you? _____

Father's Employer:_____ Job Title:_____

Why are you seeking counseling for your child at this time?

What have you done to resolve this situation?

How long has this been a challenge for you? When did it start?

Client Name: **Sunrise Counseling**

Please circle the following symptoms affecting your child. (Leave blank if not applicable):

Depression	Panic Attacks /Frequency	Feel Hopeless
Rapid heartbeat/palpitations	Think about suicide	Constant worry or anxiety
Feel irritable	Fear of social gatherings	Cry easily
Anger Outbursts	Loneliness	Unwanted / distressing thoughts
Feel guilty	Feeling worthless	thoughts of traumatic events
Phobias, unreasonable fears	Withdrawal from people	Nightmares
Unable to have a good time	Excessive bedwetting	Lost interest in usual activities
Bowel disturbances	Headaches	Peer Problems
Decreased energy/fatigue	Chronic Pain	Inattentive/distractible
Trouble staying asleep	Trouble falling asleep	Memory problems
Trouble waking up	Hyperactivity	Recent weight gain or loss
Racing thoughts	No appetite	Hear voices
Binge eating	See things	Intentional vomiting
Think about hurting someone	School problems	Repetitive behaviors
Substance abuse	Unmotivated to complete daily tasks	

-----Please explain any of the above: ----------

Does your child have any suicidal feelings? ___ For how long has he/she had them? _____

Has your child ever attempted suicide? _____ How? _____

Was your child ever in a psychiatric hospital? _____

Has your child ever been prescribed psychiatric medication?_____ Please list on back of this page_

Is your child currently taking any prescription medication?_____ Please list on back of this page_

Has your child previously seen a therapist? If so, at what age? Whom did he/she see? About how many meetings did the child/family have?

Has any member of your child's immediate family participated in mental health treatment? If so, please explain:

Has your child ever been molested? If so, when and by whom?

Parents:

If partnered, for how long: _____ If married, on what date: _____

If separated or divorced, please give the date and on the back of this page explain the circumstances, custody & visitation schedule, and communication status between parents. Additionally, please attach a copy of the custody order.

If a parent is deceased, please give the date and explain the circumstances:

Family:

Siblings Names	Ages	School

How does this child get along with her/his siblings?

About Your Child:

List any significant life traumas:

List any significant life influences:

How would you characterize your child's relationship with his/her siblings?

In your family, with whom does your child share secrets, worries, feelings?

What discipline methods have you found to be most effective with your child?

What are your child's favorite activities?

Does your child participate in any after-school activities?

Please list any chores or jobs your child has at home (e.g., babysitting, making her/his bed, taking out the garbage, etc). How well does your child carry out the above chores?

Health/Medical:

Who is your child's Primary Care Doctor?
Address/Phone:

May I contact this Doctor to coordinate care? Yes No _____(initial here)

How is your child's health?

When was your child's last complete physical?

Any medical concerns/medications?

Has your child had any serious accidents/injuries/illnesses involving such things as (circle): Convulsions, high fevers, loss of consciousness, fainting, headaches, allergies, chronic fatigue, head injuries, ear problems, or meningitis? Please explain:

Has your child ever require hospitalization? If so, please explain:

How is your child's appetite?

How many hours a night does your child sleep?

Is your child active (plays outside, does typical age appropriate activities)?

Were there any illnesses/complications during pregnancy with this child?_____

Was your child adopted? _____ If yes, at what age?_____

If adopted, please give any relevant information about biological parent history:

Did your child have history of emotional or behavioral difficulties, such as (please circle): head banging, breath holding, day soiling, excessive temper, tantrums, irritability, obsessive thoughts, compulsive need to count things or touch them, overly aggressive behavior, or difficulty controlling his/her impulses?
Approximately when did this start?

School:

Name of school:_____ Grade :_____

Does your child like school?

Favorite subjects:

Difficult subjects:

Does your child have behavior problems at school?

Has your child ever been suspended/expelled from school? If so, for what reason?

Does your child attend public or private school?

Has your child ever been home-schooled?

Schools Attended:
Elementary: _____

Middle School:_____

High School: _____

Any skipped grades? _____ What grades? _____
Any repeated grades? _____ What grades? _____

Has your child attended any gifted and talented classes?
If so, please list:

Has your child participated in special education classes? If so, please describe the type of services provided, and in which categories your child was placed:

Religion:

Religious affiliation: Church you currently attend:

Do you consider faith/religion meaningful in your life?

Drugs/Alcohol:

Are you aware of any drug or alcohol use or abuse by your child? Please explain.

Legal Involvement:

Current:

Past:

Any other relevant details that would be helpful in working with your child or family?

_____
_____
_____

Please be aware of my policies about involving me in your legal process –I am not a forensic clinician, who provides psychological services or clinical testimony for the purposes of court related or custody matters. If you are seeking a forensic clinician, please let me know, so I can refer you to an trained and experienced provider. See fees and payments for information about court related involvement.

Signature of the person completing this form date

Finanicial Responsibility: (please provide a copy of your insurance card)
Insurance Carrier: _____Phone Number on Card:_____
Policy ID Number:_____Group Number:_____

Primary Policy Holder's Name:_____Date of Birth:_____
Address, if different from Client: _____
Phone Number, if different from Client_____
Relationship to Client: _____

Primary Policy Holder's Employer:_____

Informed Consent for Treatment of a Minor

Name of Client: _____Date of Birth:_____

I, _____, as the parent of the
(Name of parent/guardian)
above child, authorize and consent for my son/daughter to receive treatment and counseling services provided by Christine Burrell Townsend, LCSW,ACSW/Sunrise Counseling.

Parents have the legal right to be appraised of the details of their minor (under the age of 18) child's treatment. Parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. However, treatment with a minor often progresses best with a good-faith agreement to confidentiality between the parents and their child so that the child can be assured of his or her confidentiality in therapy sessions. Consequently, I may discuss the treatment progress of a minor client with the parent or caretaker, but preferably not details that would decrease trust between the minor and me.

Minor clients and their parents are urged to discuss any questions or concerns that they have on this topic.

Clinical vs. Forensic Role:

In order to avoid dual relationships and conflicts of interest, I will provide you or your child with clinical services only. I do not intend to become involved in legal disputes such as personal injury lawsuits, divorce proceedings, dependency hearings or custody battles. These proceedings erode the client-therapist relationship and compromise you or your child's ability to be honest with me during treatment. In addition, I do not participate in evaluation for adoption home studies or provide evaluations of parental fitness to adoption agencies or State entities. By signing this document, you agree:

• That my role is limited to providing treatment and that you will not involve me in any legal dispute;
• That you will instruct your attorneys not to subpoena me or refer in any court filings to anything I have said or done;
• That you will not ask for my participation or recommendations in an adoption home study or dependency hearing;
• If there is a court-appointed evaluator in your child's custody or dependency dispute, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody, custody arrangements, or visitation;
• If, for any reason, I am required to provide expert testimony or documentation for a legal dispute, adoption proceeding or dependency case, or to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $150 per hour (even in the case of sliding-scale fee clients) for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

_____
Signature of Parent/Guardian Date

_____
Signature of Therapist Date

Client Acknowledgement of Receipt of HIPPA (Keep pg 6 of this document)

Notice of Privacy Practices

I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices of Christine Burrell Townsend, LCSW, ACSW, Sunrise Counseling

_____
Print Name of Client or Responsible Party (if client is under the age of 18)

_____
Signature of Client or Responsible Party

_____
Date

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your health information privacy:

As part of providing professional care, I am committed to maintaining the privacy of your personal health information. I am also required by law to keep your information private. HIPPA (The Health Insurance Portability and Accountability Act) requires that I provide you with this notice of privacy practices.

I will use information about your health mainly to provide you with treatment, to arrange payment for our services, to file claims with insurance companies, and for some other business activities that are legally referred to as "health care operations."

If it will be useful to disclose or release your information for any other purposes, I will ask you to sign an authorization form for release of information.

Your health information is confidential. However, there are instances when the law requires me to share it. For example:

• If there is a serious threat to your health and safety or the health and safety of another individual or the public. I only share information with the person or organization that is able to help to prevent or reduce the threat.

• If there is any suspicion of child abuse, neglect, molestation, or sexual abuse.

• If there is any suspicion of elder abuse or neglect.

• If you are unable to take care of basic needs for yourself.

• If disclosure of your health information is court ordered.

Your rights regarding your health information:

• You can ask me to communicate with you about your health and related issues in a way that is more private for you. For example, you can ask me to call you at work and not at home, or ask me not to leave a telephone message on a home answering machine.

• You have the right to ask me to limit what I tell people who are either involved in your care or the payment for your care, such as family members and friends. I will keep our agreement except if it is against the law, in an emergency, or when the information is necessary to treat you.

• You have the right to look at the health information I have about you, such as your treatment and billing records. Please contact me to arrange how to see your records.

• If you believe certain information in your record is incorrect or missing, you can ask me to make some kinds of changes to your health information. You must make this request in writing and tell me the reasons you want to make the changes.

• You have a right to copy of this notice. If I change this notice, I will post the new version on my website or you can obtain a new copy from me.

• You have the right to file a complaint if you believe your privacy rights have been violated. You can contact the United States Secretary of Health and Human Services at:

The Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Room 515F, HHH Bldg.
Washington D.C., 20201.

• Filing a complaint will not change the health care I provide you in any way.

If you have any questions regarding this notice or your health information privacy, please discuss them with me. My contact information is:

Sunrise Counseling
Christine Burrrell Townsend, LCSW,ACSW
License #002958
2386 Clower Street C-100
Snellville, GA 30078
770 985 2050