

**Crossroads Christian Counseling Center**  
**Child/Adolescent New Client Form**  
(to be completed carefully by parent/legal guardian)

Name of Child/Adolescent \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Home # \_\_\_\_\_ Cell # and Carrier \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

School Attending \_\_\_\_\_ Grade \_\_\_\_\_ School # \_\_\_\_\_

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**Fees and Confidentiality**

Session fee Structure: Circle the annual income of your household. Session fees are based upon a sliding scale. (All information is confidential.)

\$0-\$50,000 = \$60

\$50,001-\$75,000 = \$85

Over \$75,001 = \$95

*Payments are to be made directly to Crossroads Christian Counseling and are expected at the time of the appointment. If a conflict arises and an appointment must be cancelled, 24 hours notice is required to avoid being billed for the cancelled appointment in the amount of \$30.00.*

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**PERSONAL DATA INVENTORY**  
(PLEASE COMPLETE THIS FORM CAREFULLY)

**Marriage and Family**

Parent's Names \_\_\_\_\_ Email \_\_\_\_\_  
Marital Status (circle one): Single / Cohabiting / Engaged / Married / Separated / Divorced / Widowed

Mom's: Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # and Carrier \_\_\_\_\_  
Email \_\_\_\_\_  
Present Employer \_\_\_\_\_ Position \_\_\_\_\_

Dad's: Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # and Carrier \_\_\_\_\_  
Email \_\_\_\_\_  
Present Employer \_\_\_\_\_ Position \_\_\_\_\_

Custodial Parent(s) Name(s) \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # and Carrier \_\_\_\_\_  
Email \_\_\_\_\_

Siblings' Names	Age	Sex (M/F)	Siblings' Names	Age	Sex (M/F)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Client's Birth Order: Only Child / Oldest / Middle / Youngest / Other \_\_\_\_\_

## Child/Adolescent's Characteristics

Please circle any concern(s) applicable.

Developmental Delays	Academics	Sleep	Friendships	Suicidal Thoughts/Ideas
Anger	Envy	Appetite	Health	Emotional Behavior
Spiritual	Anxiety	Fear	Toilet Training	Family Member(s)
Substance Abuse	Social Behavior	Lying	Rebellion	Harm to Others
Impulse Control	Divorce	Sexuality	Moodiness	Deception
Physical Difficulties	Bitterness	Guilt	School	Trust
Siblings	Attention Span	Change in lifestyle	Activity Level	Depression

Other: \_\_\_\_\_ Family History of: \_\_\_\_\_

Abuse (Circle all that apply): Childhood / Physical / Sexual / Verbal / Emotional / Spiritual

Please detail any further information that may help us in the treatment of your child/adolescent. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Health

Please provide the following information regarding prescriptions the child/adolescent is presently taking:

Name \_\_\_\_\_ For \_\_\_\_\_ Dose \_\_\_\_\_ Times per Day \_\_\_\_\_

Name \_\_\_\_\_ For \_\_\_\_\_ Dose \_\_\_\_\_ Times per Day \_\_\_\_\_

Name \_\_\_\_\_ For \_\_\_\_\_ Dose \_\_\_\_\_ Times per Day \_\_\_\_\_

Date of child/adolescent's last physical exam: \_\_\_\_\_ Results: \_\_\_\_\_

List any important illnesses, injuries and/or handicaps/surgeries: \_\_\_\_\_

Past Psychiatrist/Counselor Names	Dates of Service
_____	_____
_____	_____
_____	_____

## Family History

Is there a family history of:

Health problems? Y / N If yes, what are they? \_\_\_\_\_

Depression or thoughts of suicide? Y / N Date: \_\_\_\_\_ Incident: \_\_\_\_\_

Date: \_\_\_\_\_ Incident: \_\_\_\_\_

Substance abuse? Y / N If yes, what are the circumstances? \_\_\_\_\_

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Marital difficulties/Divorce? Y / N If yes, what are the circumstances? \_\_\_\_\_

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Financial difficulties? Y / N If yes, what are the circumstances? \_\_\_\_\_

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Behavioral difficulties with other children in the family? Y / N If yes, what are the circumstances? \_\_\_\_\_

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Other sources of stress? Y / N If yes, what are they? \_\_\_\_\_

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### **Spiritual**

What importance does your faith, belief, or spirituality have to the client/client's family? \_\_\_\_\_

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Are you a part of a spiritual or religious community? How important is this to the client/client's family? \_\_\_\_\_

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May the counselor discuss these topics with your child/adolescent? Y / N

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Crossroads Christian Church offers psychotherapeutic services in conjunction with Biblical counseling. The therapy relationship is both professional and confidential. What is revealed in this setting is protected by legal, professional and ethical standards, such that, with a few important exceptions, all material is confidential and not released without your written consent. Ethically and legally, however, if there is a reasonable possibility of your harming others or yourself, the therapist is responsible to inform others in order to protect them or you. If there is a reasonable possibility of child abuse, or evidence of elder abuse, this must be reported immediately to the proper protective service. There is no statute of limitations for abuse cases so, conceivably a report on past abuse might be required in order to assure a child or elder's protection. Depending on the circumstances, a report could result in an investigation by authorities to determine if legal action is warranted. Crossroads Christian Counseling believes in the separation of church and state. Therefore, we do believe in a holistic approach to counseling where there can be, but is not mandated, outside interaction in the form of discipleship groups, worship services, etc. We are committed to protecting the privacy of the client and respect the role as a fellow worshipper, student of the Bible, etc. separate of the counseling relationship. Crossroads counselors meet weekly for supervision where cases are discussed to assure that the client is receiving the best counsel that we can provide.

I have read the above and understand that the therapy relationship is a private and confidential one with the exceptions noted above. I also agree to meet my financial obligation for each session.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

## Privacy Rule Notice

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule was instituted by the Department of Health and Human Services (hereafter, DHHS) in order to protect consumers of healthcare, providers of healthcare and healthcare networks. This law requires that healthcare providers comply with certain procedures regarding the health information of a client. In short, the HIPAA privacy rule regulates the circumstances and conditions under which a “**covered entity**” may use or disclose “**protected health information**” (PHI).

**Protected Health Information** (PHI) is any information which identifies a person and discloses information about his physical or mental health, healthcare provided to him or payment for said healthcare.

A **Covered Entity** is defined as a health plan, a health care provider who bills insurance carriers for services rendered, or a health care clearing house that processes health insurance claim forms for payment to providers.

Because Crossroads Counseling Ministries does not bill health insurance for counseling services, the counseling ministry under the privacy rule (*C.F.R. parts 160 and 164*) is not considered a covered entity. However, Crossroads Counseling Ministries follows the Code of Ethics published by the American Association of Christian Counselors (A copy of this document is available for review from the Privacy Officer) which states that we shall maintain client confidentiality to the fullest extent allowed by law (*ESI-400.1-410*). Therefore, Crossroads Counseling Ministries demonstrates a good faith effort toward following HIPAA regulations.

Under the Privacy Rule, a therapist is permitted to disclose PHI under limited circumstances without client consent or authorization. However, state law or federal law may limit or prohibit these disclosures.

Under the Privacy Rule, the permitted uses and disclosures are:

- To the client
- For treatment
- As authorized by the client

Additional uses and disclosures include those related to:

- Reporting on victims of domestic violence or abuse, as required by law
- Court orders
- Workers’ compensation laws
- Serious threats to health or safety
- Government oversight

The therapist will abide by the Privacy Rule as well as state and federal laws governing PHI. In addition, the therapist will meet the “**minimum necessary requirement.**”

### Minimum Necessary Requirement

When disclosing information, the therapist will make a reasonable effort to limit PHI to only that information which is necessary to fulfill the purpose of the use, request or disclosure.

The minimum necessary requirement does NOT apply in the following situations:

- Disclosures for treatment purposes
- Information sharing between therapist and client
- Disclosures when client authorization is given
- Disclosures required by law or for compliance with Privacy Rule

In order to ensure compliance with the minimum necessary requirement, an authorization to release information must be signed by the client. The therapist will provide the authorization form. A copy of the release form will be kept in the client record and a copy is available at the client’s request. In addition, the therapist will go over any information to be released prior to the actual release. The therapist will not use an entire clinical record except when justified to accomplish the purpose of the use, request or disclosure.

Crossroads Counseling Ministries makes every effort to ensure that PHI is kept safely and securely, with a minimal number of staff having access to that information. In our offices, the client’s PHI will be available to the client’s therapist, our secretarial staff and to the supervising therapist.

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**I have been given a copy of this form and an opportunity to read and ask questions about this document.**

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness Signature** \_\_\_\_\_ **Date** \_\_\_\_\_