7821 Maple St., New Orleans, LA 70118
(504) 303-4034
www.adenburkawright.com

CONSENT FOR TREATMENT OF A MINOR CHILD

(The following statements provide your legal consent to and financial responsibility for counseling services to a minor child. These statements are important to protect the child, the parent/guardian/conservator, and the therapist. Please carefully review this information and sign where indicated. You are requested to discuss any question you may have with the therapist.)

STATEMENT OF RESPONSIBILITY AND GRANT OF PERMISSION FOR THERAPY

I am the : Natural Parent: [ ] Legal Guardian: [ ] Managing Conservator [ ]

____

(Name of minor child)

I am legally responsible for the child named above and grant permission to Aden Burka Wright, LCSW to conduct therapy with this child.

I accept responsibility for the timely payment of all fees due to Aden Burka Wright, LCSW for services provided to this child.

Signature: _________________________________ Date: _________________

DUTY TO WARN NOTICE

Aden Burka Wright, LCSW is committed to the confidentiality and privileged communication with all clients. There are, however, several exceptions. According to Louisiana law, any evidence of child abuse must be reported to the authorities. If any individual intends to take harmful, dangerous, or criminal action against another individual, or against himself/herself, it may be the therapist's duty to report such action or intent.

Signature: ____ Date: ___________________

7821 Maple St., New Orleans, LA 70118
(504) 303-4034
www.adenburkawright.com

CHILD INTAKE FORM

Child's Given Name _________________________ Date of Birth___________

DEVELOPMENTAL HISTORY:

Was the pregnancy planned? Yes [ ] No [ ] Is child adopted? Yes [ ]

Describe any complications experienced during pregnancy
Describe any complications during birth & delivery
Did child appropriately meet their developmental milestones?

Have there been any physical or emotional separations (i.e. death, hospitalizations) between child and care taking adult during the first 5 years of life?

Yes [ ] No [ ] If yes, explain: ____

____

Is there any history that could be considered abusive?

Any previous testing?

Yes [ ] No [ ]

Dates ______________________________ Place ______________________________

Findings ____

7821 Maple St., New Orleans, LA 70118
(504) 303-4034
www.adenburkawright.com

School INFORMATION:

(please fill in where appropriate)

Teacher: ______________________ School: ______________________

Grade: ________ Year Enrolled: ____________ School Phone: ______________________

Has child been: Tutored ________ In special class: ____________ Expelled: ________ Suspended: ____________

Repeated a grade: ________ Cut classes: ____________

The school has said my child: Is hyperactive ________ Is bored ________ Procrastinates ____________

Gets along well with adults? ______________________

Enjoys School? ______________________

Strengths in School? ______________________

Weaknesses in School? ______________________

Perceives themselves to have friends? ______________________

Gets along well with students? ______________________

Has few friends? ______________________

IQ is above/below average? ______________________

FAMIILY INFORMATION:

Address:

____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ( ) ______________________

Cell/Other Phone: ( ) ______________________

May we leave a message? □ Yes □ No
May we send you text messages? □ Yes □ No

E-mail: ______________________ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Who lives in the patient's home?

____

____

Secondary Address:

____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ( ) ______________________________

Cell/Other Phone: ( ) ______________________________

May we leave a message? □ Yes □ No
May we send you text messages? □ Yes □ No

E-mail: ______________________________ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Who lives in the patient's home?

____

____

Emergency Contact:

Name:______________________Relationship:______________________

Address:____

____

Phone Number:____

PERSONAL INFORMATION:

Pediatrician: ______________________ Pediatrician's phone: ______________________

Address: ______________________ City, State Zip: ______________________

List any present medical problems and current medications: ______________________

____

Has child had counseling and/or psychiatric care? ____ Yes ____ No

If yes, when: ____

How did child feel about previous counseling experience? ____

7821 Maple St., New Orleans, LA 70118
(504) 303-4034
www.adenburkawright.com

Doctor or counselor: ____________________ Phone: ____________________

Address: ____________________ City, State Zip: ____________________

How long have you been concerned about your child's behavior/thoughts?

How does your child feel about beginning counseling?