Consent to Treat a Minor

Name of minor client: ____

Date of birth: ___________________

This is to certify that I give permission to *Mónica S. Reynoso, M.S., LMFT* for the treatment of my child(ren), ____. This treatment may include individual or family psychotherapy. This treatment may also include referrals to other appropriate State, County or other professional agencies.

One of my stipulations in treating your child is that you as a parent/guardian also be involved in the therapeutic process. By signing this consent form, you are also agreeing to attend occasional sessions at which I request your presence.

In addition, I request that my involvement in my child(ren)'s treatment include the following:

(please initial the following arrangement you are comfortable with)

_____ I would like to participate directly with my child(ren) in ongoing therapy.

_____ I will initiate periodic verbal contact for treatment updates.

_____ I feel no need at this time to be involved in my child(ren)'s treatment or to access information regarding his/her/their treatment.

_____ I give permission for Mónica S. Reynoso, M.S., LMFT to keep confidential all information shared in sessions with my child, except if she assesses my child(ren) to be at risk for suicide, homicide, or child abuse.

**I have a legal right to sole / shared medical decision making regarding the following children:

I understand that I may revoke this authorization or change participation requirements only by submitting my request in writing to *Mónica S. Reynoso, M.S., LMFT*.

___________________________________ ________________________ ____________

Signature of Parent or Legal Guardian Name (please print) Date

____ ________________________

Mónica S. Reynoso, M.S., LMFT Date

**In cases of joint custody or shared allocation of parental responsibility for medical decisions, signatures indicating consent are required from both parents in order to treat a minor, except in emergencies

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MONICA S. REYOSO, LMFT, LPCC

Child Intake Form

Name of Child: ___________________________ Age: _____ Birth Date: ___________ Gender: _______

Parent/Guardian Name: ____

Street Address: ____
City: _________________ State: _______________ Zip Code: ____________

Phone Numbers: Home: _______________ Work: _________________ Cell: __________________

Child's School/Daycare: ____

School Phone #: __________________ Grade: _________ Teacher: ___________________

Please list any medications your child is currently taking, including psychotropic medications:
____
____

Please describe any medical conditions or your child I should be aware of (allergies, injuries, illnesses, etc):
____
____

Please describe your current household composition: (names, ages, and relationship):
____
____

Reason why I am seeking treatment for my child:

____
____

What have you already tried to correct or resolve this problem?

____
____

What are you most concerned about?

____
____

What changes would you like to see as a result of therapy?

____
____

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MONICA S. REYOSO, LMFT, LPCC

Child History

Name of Child: ____________________________ Age: _________ Gender: _______________

Is your child adopted?--- yes no

Has your child ever been or is he/she currently in foster care?---------------- yes no

Explain:____

Has your child received any previous counseling or treatment?-------------- yes no

Explain:____

Were there any problems or complications during pregnancy or birth?------- yes no

Explain:____

Has your child experienced any form of abuse (physical, emotional, sexual)? yes no

Explain:____

Has your child experienced any significant trauma or losses?------------------ yes no

Explain:____

Has your child experienced any divorces or separations?----------------------- yes no

Explain:____

Does your child have difficulty at school or daycare?--------------------------- yes no

Explain:____

Does your child generally get along with other children his/her own age?---- yes no

Does your child generally get along with adults?-------------------------------- yes no

Does your child have unusual eating patterns?----------------------------------- yes no

Explain:____

Does your child have unusual sleeping patterns?-------------------------------- yes no

Explain:____

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Family History

Current custody status:

____
____

Visitation arrangements:

____
____
____

What are your main approaches to discipline?

____
____

Which approaches to discipline have shown the most success?

____
____

Which family members, including extended family, suffer from any form of mental illness?

____
____
____