CHILD REGISTRATION FORM

Lighting A New Way Counseling Services
1500 S Sycamore Ave, Suite 102
Sioux Falls, SD 57110
(605) 361-0114

_____
Date

Child's Name | Gender | Date of Birth | School & Grade

Child's Address: Street | City | State | Zip

Phone(s): *for mobile phones, please indicate name AND number*

Parent's Name(s) | Father | Mother | Custody held by

Date of Parent's Marriage(s), Separation(s), Divorce(s)

Parent address & Phone *(if different than child's)*

Level of Education | Father | Mother

Employer / Occupation | Father | Mother

Insurance Information

PRIMARY: Policy Holder Name & Date of Birth | Company | ID # | Group #

Does it cover Mental Health services? Yes□ No□ Not sure□
Is preauthorization required? Yes□ No□ Not sure□
Do you have a copay? Yes□ No□ Not sure□ If yes, what amount? _____
What is your deductible? _____ Not sure□

SECONDARY: Policy Holder Name & Date of Birth | Company | ID # | Group #

Does it cover Mental Health services? Yes□ No□ Not sure□
Is preauthorization required? Yes□ No□ Not sure□
Do you have a copay? Yes□ No□ Not sure□ If yes, what amount? _____
What is your deductible? _____ Not sure□

(please complete other side)

Others Living at Home:	Name	Gender	Date of Birth	School & Grade
Others Living at Home:	Name	Gender	Date of Birth	School & Grade
Others Living at Home:	Name	Gender	Date of Birth	School & Grade
Others Living at Home:	Name	Gender	Date of Birth	School & Grade

Health Information

Referred by Phone

Primary Concern or Complaint

Has child had any previous mental health treatment? Yes□ No□

If yes, where and with whom?

Is child currently under the care of a physician? Yes□ No□

Physician Phone

Please list medications child is currently taking:

Drug _____ Dosage _____ Schedule _____
Drug _____ Dosage _____ Schedule _____
Drug _____ Dosage _____ Schedule _____

Physican Authorization & Release

If child was referred by a physician, it is often useful for your child's therapist to confer with him/her regarding your child's diagnosis and treatment.

I, _____(parent/guardian), give permission for my child's therapist, _____(therapist), to release records and/or information about my child's treatment to my child's physician for the purpose of treatment, planning and coordinating psychotherapy with my child's health care needs. I may withdraw this consent at any time in writing or verbally, by advising the therapist named above.

I hereby authorize my child's therapist to release necessary information to insurance carriers concerning my child's diagnosis and treatment in order to process claims. In addition, I hereby authorize direct payment of medical payments to my child's therapist for services rendered.

Signed _____ Date _____

Developmental History

☐ Yes ☐ No Was pregnancy planned?

☐ Yes ☐ No Were there complications?
What?_____
Complications of birth and delivery?_____

☐ Yes ☐ No Is child adopted?
Age if/when adopted_____

☐ Yes ☐ No Problems with feeding, eating, sleeping?
When did they start?_____
Duration? _____

☐ Yes ☐ No Have there been any physical or emotional separations (i.e., death, hospitalizations, depression) between child and caretaking adult during the first 26 months of life?

☐ Yes ☐ No Is there, as far as you know, any possible history that could be considered abusive?
Please describe:_____
_____
_____

If it is hard to remember ages, please simply check the problem areas or areas you feel were/are advanced or slow in development:

Age he/she:		Does he/she:		Is he/she:	
Held head up	_____	Have blank spells	_____	Shy or timid	_____
Crawled	_____	Rock	_____	Affectionate	_____
Walked with help	_____	Shun attention	_____	Well-coordinated	_____
Used sentences	_____	Have temper tantrums	_____	Impulsive	_____
Fed self	_____	Have falling spells	_____	Right- or left-handed	_____
Dressed alone	_____	Have unusual fears	_____	Clumsy	_____
Turned over	_____	Bump head	_____		
Sat	_____	Hold his/her breath	_____		
Walked alone	_____	Show daredevil behavior	_____		
Was weaned	_____	Have sleeping problems	_____		
Said “No” to everything	_____	Have eating problems	_____		
Smiled at parents	_____				
Pull up at crib	_____				
Said 4-10 words	_____				
Helped with dressing	_____				
Dry during day	_____				
Dry during night	_____				

_____
Previous testing or therapy

_____

_____
Dates Place

_____
Findings

Symptom Checklist

Child's Name _____ Date _____

Completed by

Please place a mark in the appropriate column for each symptom as it pertains to your child. On a separate sheet of paper, please give a brief description of your child's behavior regarding each of the symptoms checked as moderate or severe.

	None	Mild	Moderate	Severe
1. Lack of impulse control	_____	_____	_____	_____
2. Self-destruction	_____	_____	_____	_____
3. Destruction of property	_____	_____	_____	_____
4. Aggression toward others	_____	_____	_____	_____
5. Consistently irresponsible	_____	_____	_____	_____
6. Inappropriately demanding and clingy	_____	_____	_____	_____
7. Stealing	_____	_____	_____	_____
8. Deceitful (lying, conning)	_____	_____	_____	_____
9. Hoarding	_____	_____	_____	_____
10. Inappropriate sexual conduct and attitudes	_____	_____	_____	_____
11. Cruelty to animals	_____	_____	_____	_____
12. Sleep disturbance	_____	_____	_____	_____
13. Enuresis and encopresis	_____	_____	_____	_____
14. Frequently defies rules (oppositional)	_____	_____	_____	_____
15. Hyperactivity	_____	_____	_____	_____
16. Abnormal eating habits	_____	_____	_____	_____
17. Preoccupation with fire, gore, or evil	_____	_____	_____	_____
18. Persistent nonsense questions and incessant chatter	_____	_____	_____	_____
19. Poor hygiene	_____	_____	_____	_____
20. Difficulty with novelty and change	_____	_____	_____	_____
21. Lack of cause-and-effect thinking	_____	_____	_____	_____
22. Learning disorders	_____	_____	_____	_____
23. Language disorders	_____	_____	_____	_____
24. Perceives self as victim (helpless)	_____	_____	_____	_____
25. Grandiose sense of self-importance	_____	_____	_____	_____

Symptom Checklist (continued)

Please place a mark in the appropriate column for each symptom as it pertains to your child. On a separate sheet of paper, please give a brief description of your child's behavior regarding each of the symptoms checked as moderate or severe.

	None	Mild	Moderate	Severe
26. Not affectionate on parent's terms	_____	_____	_____	_____
27. Intense displays of anger (rage)	_____	_____	_____	_____
28. Frequently sad, depressed, or hopeless	_____	_____	_____	_____
29. Inappropriate emotional responses	_____	_____	_____	_____
30. Marked mood changes	_____	_____	_____	_____
31. Superficially engaging and charming	_____	_____	_____	_____
32. Lack of eye contact or closeness	_____	_____	_____	_____
33. Indiscriminately affectionate with strangers	_____	_____	_____	_____
34. Lack of or unstable peer relationships	_____	_____	_____	_____
35. Cannot tolerate limits and external control	_____	_____	_____	_____
36. Blames others for own mistakes or problems	_____	_____	_____	_____
37. Victimizes others (perpetrator, bully)	_____	_____	_____	_____
38. Victimized by others	_____	_____	_____	_____
39. Lacks trust in others	_____	_____	_____	_____
40. Exploitative, manipulative, controlling and bossy	_____	_____	_____	_____
41. Chronic body tension	_____	_____	_____	_____
42. High pain tolerance	_____	_____	_____	_____
43. Tactily defensive	_____	_____	_____	_____
44. Genetic predispositions	_____	_____	_____	_____
45. Lack of meaning and purpose	_____	_____	_____	_____
46. Lack of faith, compassion, and other spiritual values	_____	_____	_____	_____
47. Identification with evil and the dark side of life	_____	_____	_____	_____
48. Lack or remorse and conscience	_____	_____	_____	_____