Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

NEW CLIENT INFORMATION FORM
12 YEARS OLD and UNDER

CLIENT INFORMATION

Client/Child Name: ______________________ Today's Date:______________________

Date of Birth: ______________________ School/Grade:______________________

Full Address: ______________________ ______________________

______________________ Parent Marital Status:

______________________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered

Parent/Guardian's Name: ______________________ Home Phone: ______________________

Parent Email:______________________ Cell Phone: ______________________

Parent/Guardian's Name:______________________ Work Phone: ______________________

Parent Email:______________________ Referred by: ______________________

Would you like to receive our FREE Newsletter? Yes ☐ No ☐

WHO ELSE LIVES IN YOUR HOUSEHOLD?

Name: ______________________ D.O.B.__________ Relationship: ☐ Child ☐ Sibling ☐ Relative

Name: ______________________ D.O.B.__________ Relationship: ☐ Child ☐ Sibling ☐ Relative

Name: ______________________ D.O.B.__________ Relationship: ☐ Child ☐ Sibling ☐ Relative

Name: ______________________ D.O.B.__________ Relationship: ☐ Child ☐ Sibling ☐ Relative

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TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S DEVELOPMENTAL HISTORY

Did this child come to you by: ☐ Birth ☐ Adoption/Foster Care ☐ Surrogacy ☐ Fertility Treatment

If by birth, was the pregnancy: ☐ Planned ☐ Unplanned

Any use of drugs or alcohol during pregnancy? ☐ No ☐ Yes, explain:______________________

Problems during pregnancy of delivery? ☐ No ☐ Yes, explain: ______________________

Developmental Milestones (Walking, talking, potty training.) ☐ Normal ☐ Delayed,
Explain____

If your child has/had any developmental delays did they receive any treatment/interventions? ☐ No ☐ Yes,Explain

____

List any history of seizures, prolonged high fevers, head injuries, poisoning, serious illness/injury?

____

Please note if your child has any special needs: ______________________________

Is there anything you want me to know about your relationship with your child?

____

EDUCATIONAL/ACADEMIC /EMOTIONAL HISTORY

Have you or your child ever had any ☐ Academic challenges ☐ Social challenges ☐ Emotional challenges

If so, Please explain:

____

Did you or your child have an IEP or 504 Plan? ☐ Yes ☐ No

If yes, would you be willing to share the IEP or 504 plan? ☐ Yes ☐ No

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TRAUMA HISTORY

Have **YOU** (parent or guardian) ever experienced any physical or sexual abuse? ☐ No ☐ Yes, When/By whom/How long?____

Was this reported? ☐ NO ☐ YES What was the outcome of the report?____________________

Has **your child** ever experienced any physical or sexual abuse? ☐ No ☐ Yes, When/By whom/How long?____

Was this reported? ☐ YES ☐ NO What was the outcome of the report?____________________

Did you or your child receive any treatment or intervention following this incident?

____

FAMILY HISTORY OF SIGNIFICANT MEDICAL ISSUES ☐ NO ☐ YES

RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT	RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT
SISTER			FATHER		
BROTHER			PATERNAL GRANDMOTHER		
MOTHER			PATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER			PATERNAL UNCLE		
MATERNAL GRANDFATHER			PATERNAL AUNT		
MATERNAL AUNT			OTHER		
MATERNAL UNCLE			OTHER		

FAMILY HISTORY OF PSYCHIATRIC DISORDERS ☐ NO ☐ YES

RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT	RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT
SISTER			FATHER		
BROTHER			PATERNAL GRANDMOTHER		
MOTHER			PATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER			PATERNAL UNCLE		
MATERNAL GRANDFATHER			PATERNAL AUNT		
MATERNAL AUNT			OTHER		
MATERNAL UNCLE			OTHER		

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FAMILY HISTORY OF DRUG/ALCOHOL/TOBACCO USE ☐ NO ☐ YES

RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT	RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT
SISTER			FATHER		
BROTHER			PATERNAL GRANDMOTHER		
MOTHER			PATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER			PATERNAL UNCLE		
MATERNAL GRANDFATHER			PATERNAL AUNT		
MATERNAL AUNT			OTHER		
MATERNAL UNCLE			OTHER		

FAMILY HISTORY OF ABUSE/NEGLECT ☐ NO ☐ YES

RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT	RELATIONSHIP TO CLIENT	TYPE OF ILLNESS	TREATMENT
SISTER			FATHER		
BROTHER			PATERNAL GRANDMOTHER		
MOTHER			PATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER			PATERNAL UNCLE		
MATERNAL GRANDFATHER			PATERNAL AUNT		
MATERNAL AUNT			OTHER		
MATERNAL UNCLE			OTHER		

CLIENT/CHILD CURRENT MEDICAL HISTORY

Name of pediatrician/physician________________________ Date of last physical________________

Address: __________________________________ Phone: ____________________

Food Allergies or intolerances:

____

Medical conditions/illnesses:

____

May I contact? ☐ NO ☐ YES

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How would you describe your child's health? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Is your child having problems sleeping? ☐ NO ☐ YES ☐ sleeping too much ☐ Sleeping too little ☐ Poor sleep quality

How many times per week does your child get exercise? ___________ What type of exercise? ________________________________

Any difficulty with appetite or eating habits? ☐ NO ☐ Yes ☐ Eating less ☐ Eating More ☐ Binging ☐ Restricting

Any significant weight change in the last 2 months? ☐ NO ☐ YES ☐ Gaining ☐ Losing

Have you or your child experienced any MAJOR life changes in the past 3-6 months? ☐ No ☐ Yes, explain:

____

6-12 months? ☐ No ☐ Yes ____

Does spirituality or religion play a role in your life? ☐ No ☐ Yes

Has your child disclosed to you any current suicidal thoughts? ☐ No ☐ Yes In the past 2 weeks? ☐ No ☐ Yes

Does your child have a history of suicide attempts or self-harming behaviors? ☐ No ☐ Yes , When and what type: ___________________

Is there a family history of suicide? ☐ No ☐ Yes , if so by whom____

Do you suspect your child may be having suicidal thoughts? ☐ No ☐ Yes

If there is anything additional that you would like to share , please do so here:

____

____

Concerns

☐ Separation anxiety

☐ Excessive fears or phobias

☐ Aggressive behaviors (hitting, kicking, biting)

☐ Frequent temper tantrums

☐ Sibling conflict

Sleep Difficulties

☐ Frequent night wakings

☐ Night Terrors

☐ Difficulties falling asleep

Toileting Issues

☐ Withholding urine or stool

☐ Bedwetting

☐ Frequent accidents

Feeding issues

☐ Picky Eating

☐ Overeating

Social Difficulties

☐ Has few friends

☐ Aggressive with peers

☐ Avoids social situations

☐ Difficulty taking turns or sharing

Other____________________________

____

____

____

LOTUS POINT
Wellness

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CREDIT CARD OR DEBIT (ACH) AUTHORIZATION

I authorize **Lotus Point Wellness, Inc.** to use the credit card or ACH information below **to charge my credit card or debit my checking/savings account using an on-line system for the following purposes:**

1. **FOR EACH SERVICE AT THE TIME OF SERVICE** provided to me/and or my child or family by the provider of Lotus Point Wellness Inc.
2. **FOR A MISSED SESSION at the rate of my regular session if I cancel less than 48 hours in advance of my appointment.**
3. **IF AND WHEN MY PAYMENT BALANCE BECOMES PAST DUE.** The provider will inform me about this charge.

I acknowledge that I will be receiving an email with a receipt for the payment and the appropriate information needed to submit to my insurance company and/or for tax purposes.

CREDIT CARD OR ACH INFORMATION Type: ☐ Mastercard ☐ Visa ☐ ACH - for checking/savings account

_______________________ _______________________ _______________________
Credit Card number 3 digit security code Expiration

_______________________ _______________________
Email for receipts Credit Card holder's name on card

____
Address of Cardholder (if different than address listed on front)

ACH: Routing number_______________________ Account Number _______________________

____ _______________________
SIGNATURE **DATE**

NEW CLIENT INFORMATION FORM
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I have been given or have been directed to the website of Lotus Point Wellness, Inc. and have read the materials provided by my treatment provider regarding Lotus Point Wellness, Inc. I/we have read and understand the background, philosophy and approach that have been disclosed in the statements for the practice AND for therapy, nutritional and/or yoga services, if applicable.

I/we also understand and accept the terms as outlined in the material provided regarding confidentiality, office policies and procedures, fees, and client rights and responsibilities, and the HIPAA policy.

I give permission for my provider of Lotus Point Wellness, Inc. to contact me and/or leave brief messages on any of my voice mails or answering machines confirming, changing or canceling an appointment with the EXCEPTION of (please initial) __home __work __cell.

I/we understand the fees as outlined in the material. Lotus Point Wellness, Inc. will provide a statement of services by e-mail or in-person at my/our session. If my/our insurance plan does not cover services provided, I/we are responsible for the payment. Extended appointments and phone consults will be charged at a pro-rated amount based on the fee for service. **I/we also understand that we need to cancel appointments 48 hours in advance by phone in order to avoid a charge for the regular session fee, unless there are extenuating circumstances, as outlined in the material provided.**

As a parent, I/we understand that I have the right to information concerning my minor child in therapy, nutrition counseling or yoga except where otherwise stated by law. I also understand that Lotus Point Wellness, Inc. believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate growth.. I/we therefore give permission to my child's therapist to use his/her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me/us.

HIPAA POLICY CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise our Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of my Notice at any time. You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked. I hereby consent to the use or disclosure of my Protected Health Information as specified above. I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lotus Point Wellness, Inc. Notice of Privacy Practices. I understand that Lotus Point Wellness, Inc. is an S Corporation and that if I have any questions regarding the Notice or my privacy rights, I can discuss them with Marie Caterini Choppin, MSW, LCSW-C (Owner/Director). Further inquiries can be addressed to the Secretary of Health and Human Services, 200 Independence Avenue, SW, Washington, D.C. or by calling 202-619-0257.

Please sign below to acknowledge that you have read, understood and agree to the terms previously described.

_______________________________________ _______________________________________ Date ____________
SIGNATURE of Client/Parent/Guardian PRINTED NAME

_______________________________________ _______________________________________ Date ____________
SIGNATURE of Client/Parent/Guardian PRINTED NAME

_______________________________________ _______________________________________ Date ____________
SIGNATURE of Therapist PRINTED NAME