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

LOTUS POINT Wellness

NEW CLIENT INFORMATION FORM
13-17 YEARS OLD

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

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
Does your child exhibit school refusal behaviors (skipping school, frequently absent, etc.) ☐ Yes ☐ No

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TRAUMA HISTORY

Have **you** 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

13200 New Hampshire Avenue
Silver Spring, MD 20904

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mchoppin@lotuspointwellness.com
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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? ☐ No ☐ Yes

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

Do you have concerns/knowledge that your child is using drugs/alcohol/tobacco? ☐ No ☐ Yes Explain,

_____

Does your child have access to drugs/alcohol/tobacco in your home? ☐ No ☐ Yes Explain,

_____

Does your child have access to firearms? ☐ No ☐ Yes explain,

_____

Do you have concerns that your child is using technology in a way that is negatively impacting their life? ☐ No ☐ Yes explain,

_____

Are there any legal issues impacting your family/child at this time? ☐ No ☐ Yes explain,

_____

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

_____

_____

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FOR ADOLESCENT TO FILL OUT - If you do not understand a question please skip it.

CURRENT REASON FOR SEEKING COUNSELING:_____

Parent Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered

Do your parents have a good relationship? ☐ No ☐ Yes

If divorced who do you primarily live with? _____

Have you experienced any emotional, physical, or sexual abuse? ☐ No ☐ Yes

If yes, please explain

_____

Family concerns (Check all that apply)

☐ Fighting	☐ Financial problems	☐ Drug use
☐ Feeling distant	☐ Death of a family member	☐ Divorce/separation
☐ Loss of Fun	☐ Abuse/Neglect	☐ Birth of a sibling
☐ Lack of honesty	☐ Feeling unsafe	☐ Other _____
☐ Physical fights	☐ Alcohol Use	
☐ Education problems	☐ Disagreeing about friends	

Do you like school? ☐ No ☐ Yes

Do you attend regularly? ☐ No ☐ Yes

What are your current grades? _____

Do you feel you are doing the best you can do in school? ☐ No ☐ Yes

Are you satisfied with your current friendships? ☐ No ☐ Yes

Are your parents happy with your friends? ☐ No ☐ Yes

Do you currently use alcohol? ____Yes, ____No

If yes, how often do you drink? ____Daily, _____Weekly, ____Occasionally, ____Rarely

If yes, how much do you drink? _____(#) per time.

Do you currently use Tobacco? _____Yes, ____No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____Yes, _____No

If yes, what drugs do you use? _____ If yes, how often do you use? ____Daily, _____Weekly, _____Occasionally, ____Rarely

Do you currently have **suicidal thoughts**? ☐ No ☐ Yes, how often? _____

If yes, do you have a plan? ☐ No ☐ Yes

Have you had suicidal thoughts in the last 2 weeks? ☐ No ☐ Yes, When? _____

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Adolescent Concerns

- ☐ Sadness
- ☐ Crying
- ☐ Sleep disturbances
- ☐ Problems at home
- ☐ Hyperactivity
- ☐ Binging/purging
- ☐ Loneliness
- ☐ Irritability
- ☐ Social Anxiety
- ☐ Self harm/cutting
- ☐ Impulsivity
- ☐ Nightmares
- ☐ Hopelessness
- ☐ Mood Swings
- ☐ Disorganized
- ☐ Grief
- ☐ Phobias
- ☐ Headaches
- ☐ Weight changes or concerns
- ☐ Appetite Changes
- ☐ Social Isolation
- ☐ Paranoid thoughts
- ☐ Poor concentration
- ☐ Indecisiveness
- ☐ Low Energy
- ☐ Excessive worry
- ☐ Low self worth
- ☐ Anger issues
- ☐ Racing thoughts
- ☐ Difficulty in school
- ☐ Easily distracted
- ☐ Alcohol use
- ☐ Obsessive thoughts
- ☐ Panic attacks
- ☐ Feeling anxious
- ☐ Suicidal thoughts
- ☐ Body image concerns
- ☐ Bullying
- ☐ Relationship issues
- ☐ Eating disorder concerns

Other_____
_____

What are some of your strengths?

1)_____

2)_____

3)_____

What do you want to work on in counseling?

1)_____

2)_____

3)_____

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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**

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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 services. 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