Daniel P. Kohen, M.D., F.A.A.P, ABMH • Developmental-Behavioral Pediatrics
Partners in Healing of Minneapolis • 10505 Wayzata Boulevard, #200
Minnetonka, MN 55305 • 763.546.5797

CONSENT FOR TREATMENT OF A MINOR

(Ages 13-18)

I agree to therapeutic services provided to my teenager by Daniel P. Kohen, M.D., at this office.

Client's Name _____

Address _____

Parent(s)/Guardian(s) Signature _____

_____

Address (if different than client's address)._____

Date_____

I/we understand that I/we have the right to information concerning my minor child in therapy, except where otherwise stated by law. (Minnesota Stat 144.341-342 except when the minor is married, legally emancipated, or has borne a child, or when information in the records concern venereal disease, chemical dependency, or pregnancy related conditions. Minnesota Statute 144.343)

I also understand that this clinician/therapist believes in providing a minor child with privacy in which to disclose herself/himself to facilitate treatment/therapy. I therefore give permission to this clinician/therapist to use his 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. (Minnesota Stature 144.335 subd 2)

Parent(s)/Guardian(s) Signature _____

Date _____

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Adolescent Intake Form

Today's Date: _____

Child's Name (First) (M.I.) (Last)		**Birthdate:**	**Age:**	**Sex** **M F**
Mother's Work Phone: **Home Phone/Mobile:**		**Father's Work Phone:** **Home Phone/Mobile:**		
Father's Name:	**Age:**	**Occupation:**		**Education Level**
Mother's Name:	**Age:**	**Occupation:**		**Education Level**
Legal Guardian (if not above): **Child currently lives with:** **Child telephone and address (if different from above)**				
Step-parents (if applicable):				

Name of person completing form_____

Please give a brief description of why you are seeking treatment:

_____
_____
_____
_____
_____
_____
_____
_____

Who referred you to me / our clinic?_____

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1. FAMILY AND SOCIAL HISTORY

Child's Siblings:	Age	Sex	At home?	Health Problem/Illness?	Adopted?

Please list anyone else living in the household? (Name, age, relationship)

_____
_____

If applicable, please give date(s) of adolescent's parents marriage, separation(s) and/or divorce:

_____
_____

Comments about custody/visitation (if applicable)

_____
_____

Please describe any family history of mental health and/or chemical dependency problems or treatment:

_____
_____

Please note any involvement with social services, child protection, the court system or legal services:

_____
_____

Do you or your adolescent believe that they have ever been hurt as noted below? Yes No
If yes, please circle:

Physically Emotionally Sexually By ways of neglect

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Has your teenager ever witnessed physical violence? Yes No If Yes, please describe:

_____

What major stresses or changes have occurred in your adolescent's life?

_____
_____
_____

Who does your adolescent regard as the most supportive in their life (specific family members, teacher, coach, friends, pets,etc.):

_____
_____

SCHOOL HISTORY

Name of current school:
_____**Grade:**_____

Current School Performance (e.g. GPA, ACT/SAT Scores?)_____

List any special services received through the school system and grade level when received services: _____
_____

Does your adolescent have behavior or social problems at school?

_____
_____

Extracurricular School Activities (Sports teams, clubs, Orchestra, etc.)

_____
_____

Is your child employed outside of the home? Yes ___ No ___ How many hours per week? __

Where:_____

Anything else we should know about school?

_____
_____
_____

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DEVELOPMENTAL HISTORY

Were there any problems during pregnancy, labor, birth or delivery with this child?

Yes No

If yes, please give details:

_____

_____

Was there any use of drugs, alcohol or nicotine during the pregnancy? Yes No If yes please note details:

_____

_____

Have there been any concerns or delays with your/your adolescent's development in any of the following areas? If yes, please indicate who evaluated the problem if help was sought:

Area	Yes	No	Evaluated by:
1. Speech and Language	Yes	No	_____
2. Hearing	Yes	No	_____
3. Vision	Yes	No	_____
4. Intelligence / ability to learn	Yes	No	_____
5. Bladder/bowel control	Yes	No	_____
6. Emotional/maturity level	Yes	No	_____
7. Social Skills	Yes	No	_____
8. Eating habits	Yes	No	_____
9. Fine Motor Skills (writing)	Yes	No	_____
10. Gross Motor Skills (walking)	Yes	No	_____

Comments?_____

_____

MEDICAL HISTORY

Primary Care Physician:_____ **Name of Clinic**_____

Date of last medical examination: _____

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Please list any current or ongoing medical problems:

_____
_____

Please note any hospitalizations (reason, dates, current status)

_____
_____

Please note any recent injuries (fractures, sprains, concussions) and current status:_____

Please note any history of surgery (operations) including reason, date(s), location (hospital, surgical center, city) and outcome (current status)

_____
_____

Please list any medication(s) currently taking, reason for medication , current dose, and name of prescribing physician:

Please list any previous medication(s) taken for psychological reasons, whether or not they were helpful, when and why they were discontinued.

_____
_____
_____
_____

Please note any drug allergies (name of medication, type of allergic/negative reaction)

_____
_____

Please note any other allergies and any medication taken for allergies

_____
_____

Have you/your adolescent had any pregnancies, miscarriages, abortions? Yes No If Yes please explain:

_____
_____

Does your teenager use any over-the-counter medications regularly/frequently? Yes No

If Yes please note:

_____
_____
_____

Does your child have any communicable diseases? (such as Tuberculosis, Hepatitis, Sexually Transmitted Diseases "STD's") Yes No If yes, please note type, date, any treatment:

_____

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_____
_____

Please add any other medical history not noted above: (Use additional pages as needed)

_____
_____
_____
_____
_____
_____

CHEMICAL USE HISTORY

Are you concerned about your teenager's use of drugs or alcohol? Yes No If yes, please check all that apply:

Alcohol _____Comments?_____
Amphetamines ("Speed")_____Comments?_____
Tranquilizers_____ Comments? _____
Narcotics_____ Comments?_____
Marijuana_____ Comments?_____
Other_____
Has your teen used more than one chemical at the same time in order to get high? Yes No
Does your teen avoid family activities so s/he can use? Yes No
Does your teen have a group of friends who also use? Yes No
Do you think your teen uses when feeling sad or depressed? Yes No
Does your child use tobacco products? Yes No If yes, indicate if cigarettes, cigars, pipe chewing tobacco and estimated quantity per day? _____

Does your child use caffeine? Yes No If yes, type?_____ Quantity per day?

_____
_____

Please note any therapists/counselors seen at present or in the past, including approximate dates and reason(s) for visits:

_____
_____
_____
_____

Please list dates and location of any psychiatric hospitalizations:

_____
_____
_____

ADDITIONAL HISTORY

What are your/your teen's favorite activities?

_____
_____

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What are your / your teen's greatest strengths?

_____
_____
_____
_____
_____
_____

What are you / your teen best at?

_____
_____
_____
_____

Is spirituality and/or faith system important to you / your teen?

_____

In your family?

_____
_____

Please note any other hobbies, sports, clubs, or other activities that you / your teen is involved in:

_____
_____
_____

Please add anything else you would like us to know: (Use additional sheets as needed.)

_____
_____
_____
_____

Teen Signature_____**Parent Signature**_____

Thank-you for completing this form!

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