COMPASS OF CAROLINA

FOR OFFICE USE ONLY: CASE # _____ PROGRAM CODE: _____

COUNSELOR: _____ SITUATION CODE: _____ Dx AXIS:_____

CLIENT FACE SHEET--MINOR

CONFIDENTIAL INFORMATION FORM **BE SURE ALL DATA IS FILLED IN**

NAME: _____ Nickname:_____

ADDRESS: _____
(STREET & NO.) (CITY) (STATE) (ZIP CODE)

TELEPHONE: _____ TODAY'S DATE: _____
(HOME)

BIRTHDATE: _____ AGE: _____ SEX: _____ RACE: (OPTIONAL) _____

SCHOOL: _____ GRADE:_____ _____

DSS/DJJ involvement? Caseworker name _____ Phone _____

Guardian Ad Litem involvement? Name _____ Phone _____

Is there a presenting concern specifically related to this child? **Please explain**

CONSENT TO TREAT MINOR

I _____ , do hereby state that I am the natural parent,
(Name of parent or guardian)
or legal guardian, having custody of _____.
(Name of Minor)
I hereby give my consent to the clinical staff of Compass of Carolina to provide mental health treatment to _____ on an ongoing basis as needed. I respect
(Name of Minor)
and agree to maintain the confidentiality needed between client and counselor. In order to preserve the therapeutic relationship and maintain confidentiality, I agree that no content of the treatment with this minor will be used in any judicial proceeding as evidence.

_____ _____
Signature of parent or guardian Date

***(if your child is 12 years or older, please have him or her complete this questionnaire)**

PROBLEM SURVEY- ADOLESCENT

NAME _____

DATE _____

	YES	NO
SCHOOL PROBLEMS	( )	( )
RELATIONSHIP PROBLEMS	( )	( )
SEXUALITY ISSUES	( )	( )
BEEN ARRESTED/PROBLEMS WITH LEGAL AUTHORITIES	( )	( )
TROUBLE MANAGING MY OWN AFFAIRS (FOOD, CLOTHING, SHELTER, WORK, SCHOOL)	( )	( )
TAKING MEDICATION	( )	( )
PREVIOUS DRUG OR ALCOHOL TREATMENT	( )	( )
DRINKING ALCOHOL OR TAKING DRUGS	( )	( )
HAVING HEADACHES	( )	( )
HAVING STOMACH PAINS	( )	( )
BELIEVE I AM BEING FOLLOWED OR PLOTTED AGAINST	( )	( )
HAVING A SPECIFIC FEAR	( )	( )
EXTREME NERVOUSNESS OR PANICKY FEELINGS	( )	( )
DIFFICULTY CONTROLLING ANGER	( )	( )
THINKING ABOUT HARMING OTHERS	( )	( )

	YES	NO
TROUBLE CONCENTRATING ON THINGS	( )	( )
TROUBLE EXPRESSING MYSELF CLEARLY OR BEING ASSERTIVE	( )	( )
TROUBLE MAKING DECISIONS	( )	( )
FEELING SAD	( )	( )
CRYING SPELLS	( )	( )
TROUBLE SLEEPING	( )	( )
FEELING HOPELESS	( )	( )
LOSING APPETITE	( )	( )
SUICIDAL THOUGHTS	( )	( )
PAST SUICIDE ATTEMPTS	( )	( )
FEELING LONELY	( )	( )
EXPERIENCE WITH ABUSE:		
PHYSICAL	( )	( )
SEXUAL	( )	( )
RAPE	( )	( )
EMOTIONAL	( )	( )