

*Into Blue Expressive Therapies*  
Parent / Guardian Consent Form

Name of child .....

Age.....

Phone no. ....Mob.....

Email .....

I give permission for .....to participate in counselling sessions with Jo Ablett. I agree / disagree to a follow up call or email from Jo.

*Please give adequate (24hrs.) notice where possible if you are unable to attend your appointment. Forgotten appointments will incur 50% of the full \$130.00 session fee. Parent interviews occur by phone or face to face prior to a session and after three sessions to assess, review and determine future direction. Fee for parent interviews \$130 hr. session.*

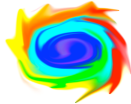
Signed ..... Date.....

Main concern / issue: .....

.....

Please indicate if any of the following are relevant to your child:

- Anger
- Abuse
- Anxieties
- Bullying
- Birth difficulties
- Changes in behaviour
- Control of emotions
- Cruelty to animals
- Depression
- Developmental concerns
- Difficulty relaxing
- Eating disorders
- Family separation
- Fears
- Grief
- Interacting with others – siblings, peers, adults
- Lack of ability to empathise with others
- Learning difficulties
- Night terrors
- Obsessive Compulsive Behaviours
- Separation anxieties
- Self-esteem
- Self-harm
- Sleeping difficulties – getting to sleep or interrupted sleep during the night?
- Social difficulties
- Violent behaviour towards others
- Withdrawal from social groups
- Trauma



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**CHILD'S MEDICAL HISTORY**

1. Pregnancy
  - Full term
  - Premature
  - Complications .....
2. Child's birth
  - Natural
  - Caesarean
  - Complications (**including PND**).....
  - Breast fed/ bottle fed
3. Major illness / medical procedures / surgery/ since birth?.....

- .....
4. Does your child suffer from?
    - Allergies ..... Parents are requested to remain on site for serious cases.
    - Asthma
    - Diabetes
    - Epilepsy
    - Headaches
    - Mental illness
    - Physical injuries
    - Problems with back, neck and shoulders
    - Stomach cramps ('sore tummy')
  5. Has your child ever had a paediatric assessment or been assessed for behavioural or learning difficulties?
    - Autism Spectrum Disorders (ASDs).
    - Asperger Syndrome
    - Attention Deficit/Hyperactivity Disorder – AD/HD
    - Obsessive Compulsive Disorder
    - Other
  6. Names of family members: .....

.....

7. Is your child currently using prescribed medication?

- .....
8. Please indicate if any of the **changes** listed below have been experienced by your child / family in the past two years:
    - Birth of a sibling
    - Child with other carers
    - Medical procedure
    - Death of a close friend or relative
    - Family separation
    - Moved house
    - Moved school
    - Parent's new partner
    - Serious illness of a close friend or family member

**COUNSELLING/ PSYCHOTHERAPY SESSIONS**

To maximise the benefit of counselling and psychotherapy it is recommended that clients commit to a minimum of three consecutive sessions. All personal information will be treated as confidential, excepting when the safety of the client or others is at risk.