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 $110.00 session fee. Parent interviews occur by phone or face to face (45 minutes $90) prior to a session and after three sessions to assess, review and determine future direction.

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?

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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.