



Into Blue Expressive Therapies
Parent / Guardian Consent Form

Name of child

Age.....

Phone no.Mob.....

Email

I give permission forto 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.

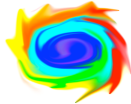
Signed Date.....

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?.....

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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.