

ASPIRE TOTAL LIFE COUNSELING (TLC)

MINOR REGISTRATION FORM

(Please Print)

| Today's date: | | Office Use Only _____ | | |
|--|--|-----------------------|---|---|
| CLIENT INFORMATION | | | | |
| Parent / Guardian's last name: | | First: | Middle: | Marital status (circle one) Single / Mar / Div / Sep / Wid |
| Minor's last name: | | First: | Middle: | Minor's birth date: / / |
| Does the minor live with the above Parent / Guardian? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> No | If "No" or "Part-time," other parent's name & phone no (for emergencies): () | | Minor's Gender <input type="checkbox"/> M <input type="checkbox"/> F | Age: Nickname / Preferred Name: |
| Street address: | | | Home phone no.: () | |
| P.O. box: | City, State, Zip | | Parent / Guardian Cell or Work no.: () | |
| I found out about TLC through... (please include names / details): <input type="checkbox"/> Therapist <input type="checkbox"/> Workshop <input type="checkbox"/> Family / Friend / Client <input type="checkbox"/> Newspaper / Radio <input type="checkbox"/> Other | | | | |
| E-mail address: | | | | |

| REASONS FOR COUNSELING | |
|--|---|
| What brings you and your child to TLC? | |
| What do you and your child hope to accomplish with these visits? | |
| Is your child currently under the care of a physician, psychiatrist, psychologist, or other licensed medical or counseling professional for any condition? <input type="checkbox"/> Yes <input type="checkbox"/> No | If "Yes," list the condition(s) your child is being treated for and any prescribed medications they currently take (Use back of form if necessary): |
| Doctor's Name: () | Doctor's phone no.: () |

| IN CASE OF EMERGENCY | | | |
|---|-------------------------|------------------------|------------------------|
| Name of local friend or relative (NOT living at same address): | Relationship to client: | Home phone no.: () | Work phone no.: () |
| <p>The above information is true to the best of my knowledge. I understand that the services at TLC are NOT conducted by a Licensed Professional Counselor, Therapist, Psychologist, or Psychiatrist as defined by Oregon State law and governed by the respective State Boards, and that TLC cannot engage in the diagnosis or treatment of specific psychological or medical conditions. I understand that all counseling and instruction my child receives at TLC is conducted by a private counselor who practices, as allowed and protected by ORS § 675.090 (f) and ORS § 675.825 (4)(a), both in a ministerial capacity and under the educational exclusion provisions therein. I acknowledge and am satisfied with the educational and ecclesiastical qualifications, as well as the authority of ordination, of my child's counselor at TLC. I am aware of my and my child's rights to self-directed care, I am responsible for my child's emotional, spiritual, and philosophic wellness, and I assent to TLC providing counseling services to my minor child of my own free and informed choice. I have received a copy of, and do understand and agree to, TLC's Privacy and Confidentiality Policies and Reporting Responsibilities. I understand that I am financially responsible for payments at the time services are rendered unless otherwise agreed upon in writing. I agree to provide at least 24 business hours' notice if I need to cancel a scheduled appointment.</p> | | | |
| _____ Client / Guardian signature | | _____ Date | |