Leslie Hannon, Psy.D., LLC

Dr. Leslie Hannon, Clinical Psychologist
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Client Information
(Guardian to fill out regarding minor)

Name of Minor _____ Age _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

School _____ Grade _____ Average Grades _____

Name(s) of legal guardian(s) _____

Guardian Email _____ Ok to leave message? Y N
(Circle one)

Guardian Work phone _____ Ok to leave message? Y N
(Circle one)

Guardian Cell phone _____ Ok to leave message? Y N
(Circle one)

Emergency Contact _____ Relationship to minor _____ Phone #_____

Who lives in the minor's home(s)? Please list first names and ages:
_____
_____
_____

Does the minor have siblings? No Yes How many? _____

What are your concerns at this time?

_____
_____
_____
_____

Please check if you have witnessed or believe the minor is experiencing the following:

___Anxiety/Panic ___Sadness lasting more than a few days ___Periods of excessive energy

___Excessive anger ___History of experiencing abuse/trauma ___Relationship issues

___Excessive spending ___Eating disordered behavior ___Suicidal thoughts

___Suicide attempt(s) ___Seeing/hearing things others do not ___Legal involvement

___Memory difficulties ___Witness/Victim of domestic violence ___Excessive Worry

___Cutting/Burning ___Alcohol/Drug/Prescription medication abuse ___Attention difficulties

Any additional symptoms? If so, please describe. _____
_____

Any current/history of significant medical issues? _____
_____

Currently, how does the minor seem to be sleeping? Any recent changes?_____
_____

Currently, how is the minor's appetite? Any recent changes? _____
_____

How would you describe the minor's recent mood? Is this normal for him/her?_____
_____

Any previous mental health treatment? (Outpatient, Inpatient, and/or Emergency Hospitalizations) Yes No
(Please circle)

Name of Provider/Agency	Dates of treatment
_____	_____
_____	_____
_____	_____

What did you like/not like about your previous experiences with the minor's mental health treatment providers? (if applicable)
_____
_____
_____

Has anyone in your family ever been treated for mental health issues? _____
_____

Has the minor ever taken or is he/she currently taking psychiatric medication? Yes No (Please circle)

Name of Medication	Dosage
_____	_____
_____	_____
_____	_____

Current medical medications (include all names & dosages):
_____
_____

Do you have any questions about therapy or anything else I can answer? _____
_____
_____

How did you hear about my services? _____
_____

_____ _____
Print Name/Date Leslie Hannon, Psy.D./Date
Licensed Clinical Psychologist

Authorization to Provide Psychological Services To a Minor

In the state of Colorado, authorization from a parent or legal guardian is required to treat minors under the age of 15. One biological parent may consent to their child's mental health treatment if the biological parents are married. If the child's biological parents are separated or divorced, both parents typically must consent to their child's mental health treatment. An exception would be if the court assigned all medical decision-making rights to only one of the parents. (Please note that this may be different from who has physical custody.) Additionally, both biological parents may have the right to review the child's records. Step-parents may not consent to the child's mental health treatment. In the state of Colorado, adolescents are granted the ability to consent to their own treatment at the age of 15 (i.e., they are able to attend treatment without permission or authorization from their parents or legal guardian).

Please review your custody agreement, and speak to me if you have questions about who will need to consent to treatment. Please check one of the following:

- The child's biological parents are married. (One or both parents may sign.)
- One of the child's biological parents is deceased.
- The child's biological parents are not married, or are separated or divorced. (Both biological parents must sign, unless the court granted all medical decision-making rights to only one of the parents.)
- A legal guardian has medical decision-making rights for the child.

I, _____ authorize Leslie Hannon, PsyD to provide:

,

___ Therapeutic Services to _____

, ___ Psychological Testing and Assessment Services to _____

I understand that this authorization is valid until the minor mentioned above reaches his/her 15th birthday, at which point the minor may consent on his/her own.

I attest that I am the legal parent or guardian of this child and have legal authorization to make care decisions for him or her.

_____ _____
Signature of Guardian Date

_____ _____
Leslie Hannon, Psy.D. Date
Licensed Clinical Psychologist