Phone 630-448-2843
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Initial Consultation

This document is intended to inform you of what to expect regarding the initial consultation. If you have other questions or concerns, please ask and we will do our best to give you the information you need. The purpose of this consultation is to gather information. We want to have a clear understanding of what you need, what you have tried, what your goals are, and how we might help. We have specialized services and want to make sure those services are a good fit for you. It is also a chance for you to interview us, learn about our services, and ask questions so you have the information you need to make an informed decision. At the conclusion of this consultation, we will both have the information we need to decide if this will be a good fit, and if so, what the path will be to ensure you accomplish your goals.

Confidentiality: Confidentiality is taken seriously. As a client, you have a right to privacy. However, under certain situations, there are limits to confidentiality. In the event a client gives information regarding the suspected abuse of a child, as a mandated reported, we may be obligated to report such information to authorities. When a client is in danger of harming him or herself or others, confidentiality may need to be broken to promote safety.

Consultation/Cancellation Policy: This consultation will be approximately 90 minutes long, although the precise length may vary. The cost is $180 and is due at the time of service. We accept cash, check, and credit cards. If you need to cancel or reschedule the appointment, please do so 24 hours before your appointment by calling 630.448.2843 and/or sending an email to dan@thecompass4life.com.

Client
Signed_____ Date_____

Parents of Child/Adolescent Questionnaire

Child/Adolescents' Name: _____ Date of Birth: _____
Home: _____ Cell Phone: _____
Age: _____ Grade: _____School_____
Parent/Guardian (filling out this form): _____
Occupation: _____
Parent/Guardian Name: _____
Occupation: _____

Siblings: _____ Age _____
_____ Age_____
_____ Age_____
__ _____ Age _____
_____ Age _____

Significant Prenatal History: N/A or YES
(Include birth trauma, pregnancy, birth defects, congenital disorders, etc.)

_____
_____
_____
_____

Significant Developmental History: N/A or YES
(atypical development including toileting, crawling, walking, talking, social development, etc.)

_____
_____
_____
_____

Special Needs: (Circle all that apply)

IEP/504	learning disabilities	glasses	prosthesis	hearing
gross motor	fine motor	information processing		allergies

Medications: (include dose/frequency/how long prescribed) _____
_____
_____

My Child/Adolescent can be best described as: (Circle all that apply)

intelligent	spirited	dramatic	friendly	intense	consistent
shy	spontaneous	focused	busy	quiet	imaginative
anxious	wise	talented	kinesthetic/physical		precocious
thoughtful	fun	organized	excitable	creative	independent
assertive					

The 3 things that concern me the most are:

1)_____
_____

2)_____
_____

3)_____
_____

The 3 Goals that I have for this process are:

1)_____
_____

2)_____
_____

3)_____
_____

My Child/Adolescent learns best learns by: (Circle all that apply)
hearing seeing doing following others

I want to improve my relationship with my child/children in the following ways:

_____
_____
_____

I will know when things are better when:

_____
_____
_____

The thing I enjoy most about my child/adolescent is:

_____
_____
_____

Client Information Form

Clients Name: _____ Date:_____
Street Address: _____
City: _____State: _____ Zip code: _____
Home Phone: _____Cell Phone: _____ Email: _____
Date of Birth: _____Age: _____Marital Status: _____
Name of Employer (or school if minor): _____
How did you find out about our services? *(circle one)* **Online? School? Other**?_____
Referral? Who referred you?_____

Credit Card Information

Card number: _____
Name on credit card: _____
Expiration date: _____
Billing zip: _____
3-digit code on back: _____