www.sageeducationcenter.com

Stephanie Johnson MA, R-DMT, LPC

Child's Name ____Age______________DOB______

Parent's Name____________________________________Email address________________________

Home Address____

Home Phone _________________________MobilePhone__________________________________

Occupation____

Parent's Name______________________________________Email Address_____________________

Address ____

Home Phone__________________Mobile Phone_____________________________________

Occupation____

Please answer the following questions to the best of your knowledge.

1. Are you the birth parent of your child?
   If no, at what age did your child join your family?
   Describe the circumstances.

2. Who lives in your home with you?

3. If parents are separated, please describe custody arrangements.

4. Does anyone in the home have a mental illness? Explain.

5. Is there anyone in the home who abuses substances? Explain.

6. Is there any abuse of any kind in the home? Explain.

7. Describe the birth of your child, please include any medical interventions including pain management and/or induction.

8. To the best of your ability , recall if and when your child:

   Lifted Head_______ Rolled over__________ Sat up without support_________

   Crawled on Belly________ Creep on Hands and Knees___________

9. Did you notice anything unique or different about your child's development in the first year?

10. When did you first become concerned about your child's development?

11. At what age did your child begin using media.   (TV, games, computer)

12. How much screen time does your child have now?

13. Does your child have epilepsy or any history of seizures?

14. Does your child have any food sensitivities or allergies?

15. What is a typical breakfast for your child?

16. What is a typical snack for your child

17. How do you describe your child's strengths?

18. How do you describe your child's peer relationships?

19. Has your child ever been diagnosed with or suspected of having a mental illness?

20. What activities outside of school does your child participate in?

21. What brings you here today?

22. What would you like the outcome of your child's treatment to be?

23. Is there anything else you would like me to know about your child and/or family?

2822 W 43rd St Mpls MN 55410
612.251.6352
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I verify that I am the custodial parent/legal guardian of this child and I give permission to Sage Education Center and Stephanie Johnson MA, R-DMT, LPC for treatment of my child. I also affirm that as custodial parent/ legal guardian I do have legal right to consent to treatment.

Childs name____ DOB________

____Date_________
Signature of guardian

Consent to Disclose

I give permission to Stephanie Johnson to disclose information regarding my child's assessment, treatment and progress to other professionals as it is relevant to their work with my child.

Child's name____DOB________

____Date_________
Signature of guardian

Disclosure Form

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Stephanie Johnson MA, R-DMT, LPC

About my Practitioner

Stephanie Johnson MA, R-DMT, LPC

1. My credentials: LPC Licensed Professional Counselor, MN Board of Behavioral Health and Therapy
   Dance Therapist Registered by the American Dance Therapy Association
   MA Somatic Psychology/Dance Therapy. Naropa University Boulder CO
   Renewable MN State Teaching License for Dance Education K-12.
   BFA Dance. Cornish College of the Arts, Seattle WA

2. Professional memberships: MN Dance Educators Coalition, American Dance Therapy Association, National Dance Education Organization, MN Department of Professional Development

Client Rights and important information:

Please read and initial each item.

___ 1.You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your child's treatment (if I can determine it), and my fee structure.

___ 2.You can seek a second opinion from another therapist or terminate treatment at any time.

___ 3.Generally speaking, the information provided by and to a client's custodial parent during sessions is confidential. In some cases it is beneficial to consult a child's teacher, this will always be discussed on a case to case basis and a *Consent to Release Information* form is part of the intake procedure at the onset of treatment.

___ 4. Session fee is $ 95.00 per 45 minute session and $65 per every 30 minute session. Fee is due at the start of each session. It is also an option to Pre-pay for the month, in this case payment for each session is $90.00 or $60. Paper work is provided to those who wish to submit claims to insurance companies.

___5.Please be on time, if you are late to a session it may not be possible to receive the total session time.

___ 6.Please do your best to cancel a session with 24 hours notice. You will be charged $25 for sessions canceled less than 24 hours in advance.

___ 6a. Please do not bring your child to therapy if he/she has a fever or has vomited within the last 24 hours of the session. It is possible to arrange make up sessions when a cancelation is necessary.

___ 7.I am available for additional parent education time. Please feel free to schedule that with me, understanding that your child's session is intended for treatment. If you should wish for me to contact your child's teacher, that can also be scheduled. The charge for parent education and teacher consultation is my hourly fee of $95.00. or $65.00 for 30 minutes. I will account for drive time to school visits.

___ 8.Shortly following the onset of treatment you will be invited to join your child's session for explanation of some activities that can be duplicated at home to support the success of your child's treatment. You will be provided with a brief written explanation of activities to reference at home. **Please understand that the rate at which your child progresses depends greatly on the frequency he/she is engaged in these activities.** If you feel it may be difficult to integrate them into your schedule, please consider scheduling more frequent treatment sessions.

___ 9. Developmental Movement Therapy often requires there to be touch between the therapist and client. This touch is used to guide movements and/or indicate to the client to focus on a particular body part. The client and/or his/her custodial guardian can always request information regarding why touch is being used and guardians are also welcome to be in the treatment room during therapy.

I, ____ have read the above disclosure and agree
Print your name here

to the conditions stated in this disclosure.

____Date____________
Client Signature

____Date___________
Stephanie Johnson, MA, DTR, LPC Sage Education Center