Private Counseling

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Intake Form - Child

Please fill out all applicable sections. If you need more space for any answer, please use the back of the sheet. Email completed form to privatecounselingga@yahoo.com

Date_____ Referred by_____ (name/organization/site)

Child's Name _____ Grade _____
Last First Middle Nickname

Date of Birth_____ Age ____ Gender: _____ School: _____

Address_____
Street City State Zip

Lives with: ____ Both Parents ____ Mom ____ Dad ____ Other: _____
If Divorced, which parent has decision making for Medical issues? _____ **Attach copy of Parental Plan**.

Mother's Name_____ DOB:_____ Cell _____
Email _____ Occupation/Length _____
Address (if different from child)_____

Father's Name _____ DOB:_____ Cell _____
Email _____ Occupation/Length _____
Address (if different from child)_____

Other Guardian/Caretaker Name _____ Relationship _____
Phone _____ Email _____

Emergency Contact: Name/Relationship _____ Phone _____

Presenting Problem

What concerns do you have about your child?_____
_____
_____
When did these concerns begin?_____
What do you think might be causing this?_____
Anyone else expressed concerns about your child?_____ Explain _____
** Denote any current concerns, frequency, and duration:

Problem	Frequency/ Duration	Problem	Frequency/ Duration	Problem	Frequency/ Duration
Failing/poor grades		Hyperactive		Physical Complaints	
Insomnia		Nightmares		Skipping School/Class	
Excessive Sleep		Stealing		Excessive Worry	
Yelling/Anger		Suicidal Ideation		Sadness	
Defiant/Disobedient		Cutting/Self-Harm		Alcohol Use	
Social Withdrawal		Delusions/Hallucinations		Drug Use	
Alcohol Use		Mood Swings		Fear of Eating	

Therapy History

Has your child ever been seen by another counselor? _____ Dates_____
Counselor Name?_____ Outcome_____
Who will participate in child's therapy? Mom: ___ Dad: ___ Step-Mom: ___ Step-Dad: ___ Other: ____
What are your expectations for therapy? _____
_____

Mental Health Status

What are the child's responsibilities?_____
Describe your child's contact with other children/Frequency: _____
_____
What are your child's favorite activities?_____
What does your child dislike doing the most?_____
What does your child like doing the most?_____
Describe your child's temperament_____
What are your child's strengths?_____
What makes your child angry?_____
Any eating problems? _____
Any sleep problems? _____ Hours per night?_____
Any fears? _____
Any gender identity issues?_____
Sensitivity to sounds, noises, textures?_____
Does your child engage in rituals or exhibit any compulsive behaviors?_____
Any separation problems?_____
Any lengthy separation from either parent?_____
Any deaths your child has experienced? _____
Relocation/Moves? When/where_____
Has child been exposed to disaster? Describe_____
Religious Preference (Optional)_____

Safety Concerns

Has your child expressed any thoughts of suicide _____ When/What:_____
Has your child ever attempted suicide? ____ Explain: _____
Does your child have any thoughts of suicide now? _____ **Official Use Only**: Safety Contract Yes/No
Has your child experienced physical, sexual, emotional or verbal abuse? Describe _____

Developmental History

Parental attitude of pregnancy_____
Was mother on medication or drugs during pregnancy? If yes, please explain_____
Child's health in 1st year _____Primary caretaker for 1st year_____
Did Mother and child attach/bond?_____ Did Father and child attach/bond?_____
Birth weight_____Age walked_____ Age talked_____ Age potty trained_____
Any speech/language issues?_____ Any problems with bed-wetting? _____

Please check (√) the appropriate box for the following areas:

Developmental Category	Below Average	Average	Above Average		Developmental History	Check (if Yes)		Developmental History	Check (if Yes)
Social					Happy Childhood			Alcohol Problems	
Emotional					Unhappy Childhood			Drug Problems	
Behavioral					Emotional Problems			Legal Problems	
Language					Behavioral Problems			Medical Problems	
Intellectual					School Problems			Religious Issues	
Physical					Family Problems			Other (explain)	

School History

Special Programs? _____ Describe_____
Please describe any academic or behavioral problems your child is experiencing in school: _____
_____
When did these begin?_____ Repeated a grade? _____ Which grade?_____
What do teachers say about your child?_____
Has your child changed schools for any reason?_____
What does your child like best about school?_____
What does your child like least about school?_____

Family History

Name of Family member	Age/ Gender	Relationship: Good/Fair/Poor	Living/Deceased
Mom:			
Dad:			
Siblings:			
Other:			

List persons living in the home with child_____
Is child adopted? _____ Date/Circumstances?_____
Divorce of biological parents? ____ Length of marriage _____
If divorced, describe your relationship with the child's other biological parent _____
_____
Dates of remarriage: Mom_____ Dad_____ Describe child's relationship with step-mom/dad_____
_____
Any history of mental illness in family, diagnosed or undiagnosed in child's blood relatives (e.g. parents, grandparents, siblings, aunts, uncles, cousins)? _____
_____
Current marital satisfaction of: Mom_____ Dad_____
Biggest struggle in your family's history_____
Current stressors in family_____
Child's reaction to birth of sisters and brothers_____

Parenting

Discipline style: Mom:_____ Dad:_____
How does each parent spend alone time with the child doing something parent and child both enjoy?
Mom _____ How often?_____
Dad_____ How often?_____
What does your family do together?_____
Are you confident in your parenting abilities?_____ Do parents support each other in parenting? _____
What desires do you have for your child?_____

Medical History

Child's Pediatrician_____ Is child currently being treated for any medical problem?_____
If yes, please explain_____
Is child currently taking any medications? If so, list_____
Was child carried full term? If no, explain_____
Any hospitalizations or surgeries? ____ Explain:_____
Any head trauma?_____ Any seizures or convulsions?_____
Any physical handicaps or deformities?_____
Any allergies or drug intolerances?_____

Name:_____
Date: _____

<u>To be completed by minor Client only</u> - Please complete the following statements:

1. I worry about

2. I am happiest when

3. What I do best is

4. I have been criticized for

5. I sometimes feel guilty about

6. It makes me angry when

7. My biggest mistake was

8. My hobby is

9. It makes me nervous when

10. My experience with religion

11. My personality would be better if

12. I often feel mother is

13. My childhood is

14. My biggest disappointment

15. I would be better liked if

16. School is

17. Boys seem to be

18. I often feel father is

19. An unspoken fear I have is

20. Girls seem to be

21. What hurts me most is

22. In relationships, I don't seem to be able to

23. My peer relationships are

24. Lately I have been feeling

25. Concerns about my body include

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Addendum – Informed Consent for Minors

Parent/Guaridan Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. **If you are separated or divorced from the child's other parent, you must provide me with a copy of the most recent custody decree that establishes custody rights for you and the other parent or otherwise demonstrates that you have the legal right to authorize treatment for your child.**

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health treatment.

Individual Parent/Guardian Communications with Therapist

In the course of my treatment of your child, I may meet with the child's parent(s)/guardians either separately or together. Please be aware that, at all times, my client is your child – not the parent(s)/guardians nor any other family members of the minor. If I meet with parent(s) or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal assess to your child's treatment record as mandated by law.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the therapist and the client. As a result, it is important for minors to have a "zone of privacy" where they feel free to discuss personal matters without fear that their thoughts and feelings will be communicated to their parents/guardians. It is my policy to provide you general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behaviors that you would not approve of or might be upset by, but that do not put your child at risk of serious or immediate harm. I will use my professional judgement to decide whether your child is in such danger and I will then communicate this information to you. Please refer to the entire Informed Consent document (available on my website) for client's rights to Confidentiality and the exceptions to this policy.

Disclosure of Minor's Treatment Records to Parents

Although the laws of the State of Georgia may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child should have a "zone of privacy" in their sessions with me. You also agree to NOT request access to your

child's written treatment records unless ordered by a Court or to transfer the record to another therapist who is serving your child.

As provided in the Informed Consent, I do not wish to be involved in the legal system or to speak to anyone regarding testifying in Court for or about my clients. If I am required to testify, I believe it will harm the therapeutic relationship. In addition, I am ethically bound NOT to give my opinion about either parent's custody or visitation suitability. Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me for payment as outlined in the Informed Consent Policy Agreement.

Parent/Guardian Acknowledgement of Addendum to Informed Consent

Each parent/guardian, please initial after each line and sign below indicating your agreement to respect your child's privacy:

- I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress and/or may be asked to participate in therapy sessions, as needed. _____ _____

- Although, I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's mental health treatment. _____ _____

- I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment. _____ _____

Client (minor) Name: _____ Date of Birth: _____

Parent/Guardian Signature _____ Relationship _____ Date _____

Parent/Guardian Signature _____ Relationship _____ Date _____

Personal Agreements

I, _____ (client name), understand that I may be asked to do certain "homework exercises" such as reading, praying, journaling, reflecting, changing behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

___ I (client) further understand that much of the work done will be to resolve issues and will depend on my honesty and willingness to do the things I need to do to move forward, even if it is emotionally painful and difficult.

___ I (client) understand that whatever I say in a session is strictly **confidential** and will not be released to anyone without my consent, **unless** I am violating codes of abuse, as outlined in the **Informed Consent**, and/or my safety is at risk.

___ I (parent/guardian) understand that I will pay in full for appointments at the beginning of each session. **In addition, sessions not canceled 48 hours in advance will require full session payment, charged to your card on file.** The session rate is $120 per session (plus $5 card processing fee).

___ I (parent/guardian) will complete the **Informed Consent** packet (p 5-7) and email it to privatecounselingga@yahoo.com prior to the initial session.

_____ _____ _____

Client Signature | Parent/Guardian Signature | Date

As your therapist/counselor, you honor me by sharing your life and growth with me. I will bring the best that I know from my training and experience. I will bring you my insight, wisdom, and emotional guidance. I will keep a holistic perspective in our work together because I believe that the Physical, Spiritual, and Mental (mind, will, emotions) all work together to form a healthy person. I will always respect your spiritual and cultural beliefs. You can expect truth from me even when you may not want to hear it. I will always have compassion and empathy for you in all that we do. I value you as a person in need of care. I will honor you in and out of sessions.

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