

Paulette Trueblood, M. A.
Licensed Marriage & Family Therapist
ADOLESCENT OR CHILD INTAKE FORM

Psychotherapy / Counseling
Individual, Couple, Family & Group

101 Harbor Rd • Southport CT 06890
Telephone: 203 254-8262

Date

Who may we thank for referring you?

INSURED PARENT INFORMATION

Name: Home Phone No:

Cell Phone No:

Address: E-mail address

Employer's Name Occupation

Work Address: Work Phone No:

Parent's Birth Date: Parent's Age:

Parent's Social Security No:

Marital Status:

SECOND PARENT INFORMATION

Name: Birth Date & Age:

Address: Phone No:

Cell Phone No:

E-mail address

Work Phone No:

Sibling Names & Ages:

CLIENT/ ADOLESCENT OR CHILD'S INFORMATION

CHILD'S NAME:

Client/ Adolescent or Child's Birth date & Age:

Client/ Adolescent or Child's Social Security No:

Child or adolescent previous counseling / therapy (include any prior history of counseling for mental health, alcohol or other drug problems:

Psychiatric	Substance Abuse	Treatment Outcomes
<input type="checkbox"/> None	<input type="checkbox"/> None	
<input type="checkbox"/> Outpatient	<input type="checkbox"/> Outpatient	
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Inpatient	
<input type="checkbox"/> Within last 12 months	<input type="checkbox"/> Within last 12 months	
<input type="checkbox"/> One prior admission	<input type="checkbox"/> One prior admission	
<input type="checkbox"/> 2 or more prior admission	<input type="checkbox"/> 2 or more prior admissions	

Child's Medical history

Major illnesses (physical or mental), injuries or chronic problems, which have required attention over the years?

Is the child currently taking any medication? Yes No

If yes, who prescribed & for what condition?

List child allergies?

Is there any medical illness, alcoholism, substance abuse or psychological disorder that seems to run in the family? Please explain.

Has any significant personal or family event occurred recently? Circle event on list below. Indicate when & briefly describe. Use reverse side of this sheet, if necessary.

A. Death

B. Pregnancy / Birth

C. Separation / Divorce (or threat of)

D. Child entered school for first time

E. Child reached adolescence

F. Career or business readjustment

G. Accident or serious injury / illness (you or family)

H. Serious trouble (you or family)

I. Mid-life change

INSURANCE INFORMATION

Insured's Name:

Insured's Birth Date:

Insured's Social Security No.

Insurance Co:

Insured's ID #:

Insurance phone #

Client's Insurance ID#:

Insured's Employer:

Secondary Insurance Co:

Secondary Insurance ID #:

Primary Care Physician's Name & Address (required by BC/BS, Anthem):

Do you give me permission to communicate with your child's primary care physician regarding sessions with me in order to coordinate care? Yes No

If no, explain:

BOTH PARENTS ARE REQUIRED TO SIGN

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE FOR INSURANCE AUTHORIZATION: the statements are true and correct to the best of my belief. I authorize any insurance company, organization, hospital, physician or other healthcare vendor providing service or benefits to me to release any mental health, substance abuse, assessment or medical treatment information necessary to affect treatment or claim payment. I understand that confidential mental health and medical information will not be released to my employer, family members or others not identified without my consent.

I authorize payment of medical benefits to the Paulette Trueblood MA, LMFT for individual psychotherapy (90801, 90804 or 90806), Family Psychotherapy (90846, 90847), and Group Therapy (90853).

Parent/Guardian Signature #1

Date

Parent/Guardian Signature #2

Date

I send information to clients about classes that I teach as well as articles of interest. If you **do not** want to be on the mailing list please initial here.....

Client Name: _____ Date: _____

Symptoms (Please check all that apply. Those not checked will be assumed absent.)

Depressed mood <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Hyperactivity <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Emotional/physical/sexual trauma victim
Decreased energy <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Impulsivity <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Emotional/physical/sexual trauma perpetrator
Feel hopeless <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Distractible <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Substance Abuse Active
Feel helpless <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Elevated Mood <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Substance Abuse Early Full Remission
Feel guilty <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Worry <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Substance Abuse Partial Remission
Feel unmotivated <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Anxious <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Substance Abuse Sustained Full remission
Feel irritable <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Panic Attacks <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Substance Abuse Sustained Partial Remission
Feel overwhelmed <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Hallucinations <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Do you have suicidal thoughts? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe
Mood Swings <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Persistent ideas, thoughts, images that cause marked anxiety or distress <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Do you have a plan for suicide? Do you have the means to commit suicide?
Problems concentrating <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	At times, do you feel like an outside observer of your actions? (depersonalization) <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Do you have homicidal thoughts? Please explain.
Problems falling asleep? Awaking during sleep & problems falling back asleep?	Repetitive mental acts the goal of which is to prevent anxiety (counting, praying) <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	At times, do you feel like you live in a dream or movie? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe
Waking too early?	Repetitive behaviors the goal of which is to prevent anxiety (ordering, checking, washing) <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Complaints about bodily pains <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe

Number of cigarettes smoked per month? Per week? Per day?	Number of alcoholic beverages consumed per month? Per week? Per day?
Do you use illegal drugs?	If yes, what illegal drugs do you use? How often?

TREATMENT PLAN

AXIS I:	AXIS II:	AXIS III:
AXIS IV:	AXIS V:	
PROBLEMS:		
GOALS:		
OBJECTIVES/APPROACHES:		
090905		

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INFORMED CONSENT AND AUTHORIZATION PSYCHOLOGICAL TREATMENT

Sessions are 45-50 minutes. Fees for clients using health insurance vary, and are determined by the insurance company contract agreement with P. Trueblood. Client responsibility with insurance is usually a co-pay and/or deductible. If the client's insurance company does not pay for the sessions, the standard fees are the client's responsibility. Standard fees are \$135 for the first evaluation session and \$110 for following sessions.

Scheduled sessions that are cancelled less than 24-hours in advance are subject to a \$70 missed session fee.

I understand that P. Trueblood, MA, LMFT will provide me with mental health services. These services may consist of interviews, treatment sessions, the administration of various self-evaluation scales, the review of various documents and records from my background, and interviews with other individuals who are familiar with me. Everything that is said during the course of my treatment is protected under my rights to confidentiality and will not be conducted or released without my expressed and written authorization.

I realize that certain types of information revealed during the course of these services may result in other agencies or people being notified, even though they are not directly involved in my treatment. Examples of such information include reports of child abuse (past and present), elder and/or dependent adult abuse, threats to kill or violently harm others, and threats to harm myself.

A limited exception to confidentiality may exist in the case of third-party payers (insurance companies, employee assistance plans, victims assistance programs, and health maintenance organizations), and will be limited to reporting my diagnosis and treatment needs in order to satisfy billing requirements. I also understand that in the case of delinquent accounts, a collection agency may be employed to seek payment; however, information released to them will consist solely of session dates and account balances.

I understand that at times Paulette Trueblood may use various professional copying, test scoring and other professional services and that she may consult with other professionals as part of ongoing professional education, research and workshop presentations. At all times P. Trueblood will protect my privacy by not revealing my name or other unique identifying characteristics

I understand that there may be alternative treatment methods for my condition, and that I can discuss these alternatives with Paulette Trueblood at any time. I also understand that I may choose to terminate treatment at any time with the understanding that a final session focused on termination issues is advisable. I am aware that there are risks associated with psychotherapy – and these may include lack of improvement, disruptions in my life that can occur as a result of therapeutic changes, and emotional pain associated with the exploration of personal issues.

I have read (or have had read to me) the information in this authorization and consent and I have asked questions about anything I have not understood. By signing this form, I freely acknowledge my willingness to undergo the treatment to be performed by Paulette Trueblood and release her of any liability that might directly or indirectly result from the release or exchange of any information covered by this form. We will provide you with a copy of this form on request.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

Signature 1 _____ Signature 2 _____ Dated _____

Parent or guardian signature _____ Dated _____

Therapist _____ Dated _____