Paulette Trueblood, M. A.
Licensed Marriage & Family Therapist
Psychotherapy/Counseling
Individual, Couple, Family & Group
101 Harbor Rd • Southport CT 06890
Telephone: 203 254-8262

ADOLESCENT or CHILD INTAKE FORM

DATE:

WHO MAY WE THANK FOR REFERRING YOU?

WHAT ARE THE PROBLEMS OR ISSUES THAT BRING YOU TO COUNSELING?

WHAT DO YOU HOPE WILL CHANGE? WHAT ARE THE GOALS FOR COUNSELING?

CHILD OR ADOLESCENT'S INFORMATION:

Child Name:

Child Age & Birthdate: | Child's Social Security No:

Marital Status of Parents?

Sibling Names & Ages:

INSURED PARENT INFORMATION

Name: | Home Phone No:
Cell Phone No:
Address: | E-mail address

Parent's Age & Birth Date: | Parent's Social Security No:

Employer's Name | Work Phone No

SECOND PARENT INFORMATION

Name: | Home Phone No:
Cell Phone No:
Address: | E-mail address

Parent's Age & Birth Date: | Parent's Social Security No

Employer's Name | Work Phone No

CHILD OR ADOLESCENT'S PREVIOUS COUNSELING OR THERAPY HISTORY:

Mental Health	Substance Abuse	Treatment Outcomes
☐ None	☐ None	
☐ Outpatient	☐ Outpatient	
☐ Inpatient	☐ Inpatient	
☐ Within last 12 months	☐ Within last 12 months	
☐ One prior admission	☐ One prior admission	
☐ 2 or more prior admission	☐ 2 or more prior admissions	

CHILD OR ADOLESCENT'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, for what condition?

Prescribing Physician's Name, Address & Phone No:

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 family event occurred recently? Death, Pregnancy/Birth, Divorce (or threat of), Accident or serious injury/illness, Serious trouble? Describe:

INSURANCE INFORMATION

Policy Holder's Name:	Policy Holder's Birth Date:
Policy Holder's Social Security No.	
Insurance Co:	Policy Holder's ID #:
Insurance phone #	Child's Insurance ID#:
Policy Holder's Employer:	
Secondary Insurance Co:	Secondary Insurance ID #:

Pediatrician's Name, Address & Telephone Number:

Do you give me permission to communicate with your child's pediatrician or medication management professional 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**

Child's Name: _____Date:_____

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

Feels unhappy or sad ☐Mild ☐Moderate…☐Severe	Hyperactivity ☐Mild ☐Moderate…☐Severe	Emotional/physical/sexual trauma victim?
Depressed mood ☐Mild ☐Moderate…☐Severe	Impulsivity ☐Mild ☐Moderate…☐Severe	Emotional/physical/sexual trauma perpetrator?
Decreased energy ☐Mild ☐Moderate…☐Severe	Distractible ☐Mild ☐Moderate…☐Severe	Destroyed property?
Feels overwhelmed ☐Mild ☐Moderate…☐Severe	Moods Change quickly ☐Mild ☐Moderate…☐Severe	Behavior caused school problems?
Loss of interest in things ☐Mild ☐Moderate…☐Severe	Worries too much ☐Mild ☐Moderate…☐Severe	Used Alcohol?
Feels unmotivated ☐Mild ☐Moderate…☐Severe	Worry interferes with life ☐Mild ☐Moderate…☐Severe	Substance Abuse Problems?
Temper outbursts ☐Mild ☐Moderate…☐Severe	Complaints of pounding or racing heart ☐Mild ☐Moderate…☐Severe	Has there been evidence of self-harm?
Feels irritable ☐Mild ☐Moderate…☐Severe		Hallucinations? ☐Mild ☐Moderate…☐Severe
Decrease in appetite ☐Mild ☐Moderate…☐Severe Unusual increase in appetite ☐Mild ☐Moderate…☐Severe	Persistent ideas, thoughts, images that cause marked anxiety or distress ☐Mild ☐Moderate…☐Severe	Eating Problems: ☐Binging ☐Purging ☐Restricting
Problems concentrating ☐Mild ☐Moderate…☐Severe	At times, do you feel like an outside observer of your actions? (depersonalization) ☐Mild ☐Moderate…☐Severe	Are there thoughts of harm or death to others? Please explain.
Isolating ☐Mild ☐Moderate…☐Severe	Are repetitive mental acts used to prevent anxiety (counting, praying) ☐Mild ☐Moderate…☐Severe	Has there been talk of not wanting to live? ☐Mild ☐Moderate…☐Severe
Sleep Problems: ☐Falling asleep? ☐Awaking during sleep? ☐Waking too early? ☐ Sleeping too much	Are repetitive behaviors used to prevent anxiety (ordering, checking, washing) ☐Mild ☐Moderate…☐Severe	Has there been talk of a plan for suicide? Has there been an attempt?

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:		

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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 $150 for the first evaluation session and $135 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.

PARENT OR GUARDIAN SIGNATURES

Signature 1 _____ Dated _____

Signature 2 _____ Dated _____

Therapist _____ Dated _____

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