CHILD/ADOLESCENT INTAKE FORM

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: Home Phone No:

Cell Phone No:

Address: E-mail address

Work Phone No:

SIBLING'S NAMES: Birth Date Age:

Birth Date Age:

Birth Date Age:

CLIENT/ ADOLESCENT OR CHILD'S INFORMATION

NAME:

Birth date & Age:

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
☐ 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'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

Client Name: ____**Date:**__________________

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

Depressed mood ☐Mild ☐Moderate ☐Severe	Hyperactivity ☐Mild ☐Moderate ☐Severe	Performed repetitive behaviors the goal of preventing anxiety (ordering, checking, washing) ☐Mild ☐Moderate ☐Severe
Decreased energy ☐Mild ☐Moderate ☐Severe	Impulsivity ☐Mild ☐Moderate ☐Severe	Performed repetitive behaviors the goal of preventing anxiety (ordering, checking, washing) ☐Mild ☐Moderate ☐Severe
Feel hopeless ☐Mild ☐Moderate ☐Severe	Distractible ☐Mild ☐Moderate ☐Severe	Complaints about bodily pains ☐Mild ☐Moderate ☐Severe
Feel helpless ☐Mild ☐Moderate ☐Severe	Elevated Mood ☐Mild ☐Moderate ☐Severe	Emotional/physical/sexual trauma: victim
Feel guilty ☐Mild ☐Moderate ☐Severe	Worry ☐Mild ☐Moderate ☐Severe	Emotional/physical/sexual trauma: perpetrator
Feel unmotivated ☐Mild ☐Moderate ☐Severe	Anxious ☐Mild ☐Moderate ☐Severe	Alcohol use problems Explain:
Feel irritable ☐Mild ☐Moderate ☐Severe	Panic Attacks ☐Mild ☐Moderate ☐Severe	Substance abuse problems Explain:
Feel overwhelmed ☐Mild ☐Moderate ☐Severe	Hallucinations ☐Mild ☐Moderate ☐Severe	Suicidal thoughts? ☐Mild ☐Moderate ☐Severe
Mood Swings ☐Mild ☐Moderate ☐Severe	Persistent ideas, thoughts, images that cause marked anxiety or distress ☐Mild ☐Moderate ☐Severe	A plan for suicide?
Problems concentrating ☐Mild ☐Moderate ☐Severe	Talked about feeling like an outside observer of his/her actions? (depersonalization) ☐Mild ☐Moderate ☐Severe	The means to commit suicide?
☐ Problems falling asleep? ☐ Awaking during sleep & difficult falling back asleep? ☐ Waking too early?	Repetitive mental acts the goal of which is to prevent anxiety (counting, praying) ☐Mild ☐Moderate ☐Severe	Homicidal thoughts? Please explain:

TREATMENT PLAN

DIAGNOSIS:
PROBLEMS:
GOALS:
OBJECTIVES/APPROACHES:

INFORMED CONSENT AND AUTHORIZATION FOR PSYCHOLOGICAL TREATMENT

Sessions are 30 minutes. Standard fees are $50 for 30 Minutes. Scheduled sessions that are cancelled less than 24-hours in advance are subject to a $50 missed session fee. Paulette Trueblood will provide a form that clients can use to submit to their health savings account or insurance provider for fee reimbursement.

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 or kill 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.

BOTH PARENTS' SIGNATURE REQUIRED

Parent or guardian signature 1 ____ Dated________

Parent or guardian signature 1 ____ Dated________