

**ADOLESCENT or CHILD INTAKE FORM**

**Date:**

**Who may we thank for referring you?**

**WHAT ARE THE PROBLEMS OR SYMPTOMS 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:

Social Security #:

Marital Status of Parents:

Sibling Names & Ages:

**INSURED PARENT INFORMATION**

Name:

Home Phone #:

Cell Phone #:

Address:

E-mail address

Parent's Age:

Birth Date:

Social Security #:

Employer's Name

Work Phone #:

**SECOND PARENT INFORMATION**

Name:

Home Phone #:

Cell Phone #:

Address:

E-mail address:

Parent's Age:

Birth Date:

Social Security #:

Employer's Name

Work Phone #:

**CHILD OR ADOLESCENT'S PREVIOUS COUNSELING OR THERAPY HISTORY:**

Mental Health	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 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 #:

List child allergies, if any:

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:

Birth Date:

Policy Holder's Social Security #:

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: \_\_\_\_\_  
 Person Filling this Form: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

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

Feels unhappy or sad <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?
Depressed mood <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?
Decreased energy <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	Destroyed property?
Feels overwhelmed <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Moods Change quickly <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Behavior caused school problems?
Loss of interest in things <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Worries too much <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Used Alcohol?
Feels unmotivated <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Worry interferes with life <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Substance Abuse Problems?
Temper outbursts <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Complaints of pounding or racing heart <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Has there been evidence of self-harm?
Feels irritable <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
Decrease in appetite <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe Unusual increase in appetite <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	Eating Problems: <input type="checkbox"/> Binging <input type="checkbox"/> Purging <input type="checkbox"/> Restricting
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	Are there thoughts of harm or death to others? Please explain.
Isolating <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Are repetitive mental acts used to prevent anxiety (counting, praying) <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe	Has there been talk of not wanting to live? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> Severe
Sleep Problems: <input type="checkbox"/> Falling asleep? <input type="checkbox"/> Awaking during sleep? <input type="checkbox"/> Waking too early? <input type="checkbox"/> Sleeping too much	Are repetitive behaviors used to prevent anxiety (ordering, checking, washing) <input type="checkbox"/> Mild <input type="checkbox"/> Moderate... <input type="checkbox"/> 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**

<b>AXIS I:</b>	<b>AXIS II:</b>	<b>AXIS III:</b>
<b>AXIS IV:</b>	<b>AXIS V:</b>	
<b>PROBLEMS:</b>		
<b>GOALS:</b>		
<b>OBJECTIVES/APPROACHES:</b>		

**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 \$175 for the first evaluation session and \$150 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 \_\_\_\_\_