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Woodstock, GA 30188
770.605.9543

Child / Adolescent Client Intake Information

The purpose of the following questionnaire is to help your counselor understand some important things about your child in order to help your child and your family most effectively. Please complete all pages.

Child's Full Name: _____ Date: _____

Child's date of birth: _____ Age: _____ Sex:_____ Race: _____

Address: _____

Telephone numbers: Home:_____ Cell:_____ Work:_____

Is it okay to leave a message at home/ cell/ on work phone: _____

E-mail Address: _____

Caregiver/Parent Name(s): _____

Caregiver/Parent(s) date of birth: _____

Emergency Contact: Name: _____ Phone Number:_____

Marital Status:

Single_____ Divorced_____ Engaged_____

Separated_____ Widowed_____ Other_____

Married_____ No. of Years_____ Name of Spouse_____

Spouse's Age_____ Spouse currently living with you?_____

Previous Marriages (Nos. and length of each)_____

Custody Status: _____

How did you hear about Tracy? _____

Presenting Problem:

Please circle stressors you have had in recent months:

Marital Issues Health Issues Job Issues Financial Issues Parent/Child Issues

Issues in Past Other: _____

Child's Presenting Problem(s): (please circle all that apply)

Sexual abuse	Physical abuse	Neglect	Delinquent behavior	Nightmares
Suicidal thoughts	Sexually acting out	Sleeping problems	Anxiety	Shyness
Academic problems	Change in appetite	Concentration	Bed wetting	Stealing
Clinging behavior	Impulsivity	Temper outbursts	Withdrawn	Lying
Peer conflict	Drug use	Alcohol use	Stubborn	Running away
Missing school	Health issues	Strange thoughts	Legal trouble	Harming self
Head banging	Overactive	Skipping school	Sexual problems	Fearful

Other problems and/or concerns: _____

_____

How long have these problems occurred (number of weeks, months, years): _____

_____

Why did you decide to seek counseling at this time?_____

_____

Describe how you hope counseling will help your child: _____

_____

Describe how you hope counseling will help you and your family:_____

_____

Psychosocial History:

Current Family Situation:

List the occupants in the home, even if temporary:_____

_____

Biological siblings (list names and ages in order of oldest to youngest):_____

_____

Are there any current concerns regarding siblings (please list concerns)?_____

_____

Has the child ever been exposed to domestic violence? _____

_____

Traumas or losses (please indicate the loss or trauma and the age of the child)_____

_____

_____

_____

Living Arrangements:

Is there currently a custody dispute? ____yes ____no _____possibly

Is there weekend visitation with a non-custodial parent? _____yes _____no

Has your child recently moved? ____yes _____ no Number of moves in child's life: _____

Who makes the decisions regarding the household money, discipline, routine:_____

_____

What is your major form of discipline? (example: grounding, spanking, taking away TV, etc.)_____

_____

Who is the major disciplinarian? _____

Physical / Mental Health of Client and Family Members

Please note all health problems <u>your child</u> has had or has now:

	Age:		Age:		Age:		Age:
High fever	_____	Dental problems	_____	Dizziness	____	Sinus problems	_____
Pneumonia	_____	Weight problems	_____	Tonsils out	____	Heart problems	_____
Flu	_____	Allergies	_____	Vision problems	____	Hyperactivity	_____
Encephalitis	_____	Skin problems	_____	Hearing problems	____	High/Low	
Meningitis	____	Asthma	_____	Earaches	____	Blood pressure	_____
Convulsions	____	Headaches	_____	Fainting	____		
Unconsciousness	____	Stomach problems	_____				
Convulsions	____	Accident prone	_____				
Head injury	____	Anemia	_____				

Major illness or physical limitations? _____
Has your child ever been hospitalized? If so please explain:_____

Please list all medications your child is taking: _____

Name of primary care physician:_____
Name of other physicians your child is seeing, especially psychiatrists:_____

Has your child ever seen a therapist before? ____yes _____no Name of therapist:_____
What was the presenting problem? _____
Duration of therapy: _____
Has your child ever had a psychiatric diagnosis?_____

Family Medical and Psychiatric History:
Medical problems or disabilities in the family:_____

Psychiatric history in family:_____

Substance abuse history:_____

Developmental History

Prenatal:
Please list any problems or complications with pregnancy or delivery: _____

Developmental Milestones:
(Referring to age when the child walked, talked, potty trained, etc.)

Additional Comments:_____

Educational History:

Name of child's school:_____Grade: _____
Teacher(s) name:_____Average grades:_____
Concerns regarding school academics or behavior:_____

Have there been any significant changes or problems in school behavior or grades?_____

Child's best subject:_____ Child's most challenging subject:_____

Please check the following according to your child:
Learning disabilities? _____yes _____no If yes, please explain?_____
Gifted program? _____yes _____no
ADHD? _____yes _____no

Participate in extracurricular activities? _____yes _____no (explain)_____

Social history

In school how many friends does your child have: _____a lot _____a few _____none
How much time does your child spend with other children outside of school during the week?
0-1 day_____ 2-3 days_____ 4-5 days_____ more than 5 days_____

Please list child's special interests, hobbies, skills:_____

Who does your child spend most of his/her time with?

How does your child get along with:

Peers?

Adults?

Teachers?

Parents?

Other?

Is your family connected with other groups, churches, or religious organizations?

Has your child ever had difficulty with the police? _____yes _____no (explain if yes)

Has your child ever been on probation? _____yes _____no

Is your child employed? _____yes _____no

Additional comments, questions, or concerns:

Signature: _____ Date: _____

For Teens Only
Please Complete the Following Sentences

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 like my mother is

13 My younger childhood was

14 My biggest disappointment

15 I would be better liked if

16 I think sex is

17 Boys seem to be

18 I often feel my 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 girlfriend/boyfriend is

24 Lately I have been feeling

Policies

Please initial where indicated, stating you have read and understood the information provided

Confidentiality: A very important aspect of developing the openness, honesty, and trust between counselor and client is confidentiality. Whatever you share with me will be kept in the strictest confidence and will not be disclosed to anyone without your express, written consent. At the same time, it is important for you to know that under Georgia law, a few situations sometimes arise in which I am both legally and ethically required to make disclosures that are necessary to ensure the safety of yourself or others. Those situations include: suspected child abuse, threat of physical violence to others, suicidal intent. I will further discuss any aspect of confidentiality, which may concern you, including any information requested by your insurance company. **Initials** _____

Court: I do not participate in divorce or child custody proceedings because the same professional should not perform evaluation and therapy. Under the circumstances that I am subpoenaed to appear in court or have to put together a sworn affidavit, **I will bill at $200 an hour for all time (consultation, phone calls, emails, texts, travel time, etc.) spent on the case.**
Initials _____

Emergencies: If you have an emergency (something that cannot wait for your next appointment), please call me at 770.605.9543. All calls are returned within 24 hours or the next business day. If you feel that you cannot wait, please call 911 or go to the nearest Hospital Emergency Room for help. Please do not wait for me to contact you to utilize those resources.
Initials _____

Insurance: I do not currently insurance. Since each insurance company is different in the health benefits it provides, there can be no guarantee that the counseling services you receive will be covered. Although I am a qualified and licensed professional, exact requirements for payment vary. You should be able to ascertain your plan's eligibility from your agent, your insurance company, or your employer. In the event that your insurance company requires correspondence with me in order to reimburse you for services provided by me, you will be asked to provide specific written consent for the me to communicate with your insurance company. Please let me know if you intend to file a claim.
Are you planning to file a claim for reimbursement of services with your mental health insurance provider? _____ **Y** _____ **N** **Initials** _____

Cancellation Policy: : Cancellations can be made over the phone, through text or email; however you must receive a reply from me that I have gotten your message of cancellation or it will not be accepted. I will confirm your cancelled appointment over the phone. For cancellations occurring at least 24 hours prior to your appointment time, no charges will be incurred. For cancellations occurring less than 24 hours in prior to your appointment time, the **full charge for your scheduled session will be applied**. For appointments not kept (and not cancelled) the **full amount will be charged**. For those who are on a sliding scale, the full rate (not the sliding scale rate) will be charged. **Initials** _____

Payment and Returned Check Fee: Payment in full is due when services are rendered unless other arrangements have been made with me in advance. Fees are charged for sessions, phone consultations and report writing. There is a $30 returned check fee in addition to the fee for service.

Please sign below, indicating that you have read, understood, and received a copy of this information. If you have any questions or concerns, please discuss before signing.

Client Signature: _____ Date: _____

Keep This Copy For Your Records

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Insurance: I do not currently insurance. Since each insurance company is different in the health benefits it provides, there can be no guarantee that the counseling services you receive will be covered. Although I am a qualified and licensed professional, exact requirements for payment vary. You should be able to ascertain your plan's eligibility from your agent, your insurance company, or your employer. In the event that your insurance company requires correspondence with me in order to reimburse you for services provided by me, you will be asked to provide specific written consent for me to communicate with your insurance company. Please let me know if you intend to file a claim.

Cancellation Policy: Cancellations can be made over the phone, through text or email; however you must receive a reply from me that I have gotten your message of cancellation or it will not be accepted. I will confirm your cancelled appointment over the phone. For cancellations occurring at least 24 hours prior to your appointment time, no charges will be incurred. For cancellations occurring less than 24 hours in prior to your appointment time, the **full charge for your scheduled session will be applied**. For appointments not kept (and not cancelled) the **full amount will be charged**. For those who are on a sliding scale, the full rate (not the sliding scale rate) will be charged.

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Consent to Treat a Minor

We, (Parents Names) _____ and _____, are legal custodial parents with decision-making responsibility for (Minor's Name) _____, a minor. (If sole legal custodian please attach a copy of Permanent Court Order Provision.)

We authorize Tracy Brodrick, MA, LPC in her capacity as a Licensed Professional Counselor to begin the mental health assessment and treatment of said minor on (Date) _____. Authorization will be in effect until such time as this psychotherapeutic relationship is terminated.

As legal custodial parent, we understand that we have the right to information concerning our minor child in therapy, except where otherwise stated by law. We also understand that this therapist believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. We therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with us. This is my written consent to the mental health assessment and treatment of minor child under the terms stated above.

Both parents must consent for treatment unless the treatment is court ordered or one parent is sole legal custodian (please attach provision).

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Witness/Provider Date

Please sign below and keep the two subsequent pages of information for your records.

Georgia Notice Form

By signing below, I am acknowledging that I have received a copy of the Georgia Notice Form concerning the policies and practices protecting my health information.

Signed_____ Date_____

Georgia Notice Form

Notice of Licensed Professional Counselor Policies and Practices
to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Heath Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- “Treatment” is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as a family physician or another psychologist.
- “Payment” is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health care insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- “Health Care Operations” are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides that insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

- Adult and Domestic Abuse: If I have reasonable cause to believe that a disabled adult or elder person has had physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- Health Oversight Activities: If I am the subject of an inquiry by the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.

- Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order.

- Serious Threat to Health or Safety: If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- Workers Compensation: I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Licensed Counselor's Duties

Patient's Rights:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction that you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss the details of the request and denial process.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Licensed Counselor's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will inform you of that change in a session or on the phone, and that information may be also provided to you in written form while you are in a session or through the mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please inform me. You may also contact the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, I will promptly distribute the revised Notice, post it in the waiting area of my office, and make copies available to my patients.