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MFC 44834

Minor Child Intake

Date______________
Child's Name_______________________________ Age_________ Birthdate________________
Address____
City____________________________________Zip___________________
Home Phone ______________ Work _______________ Cell _______________
Is it O.K. to call you at home? ______ At work?_______ Cell? ________
May I identify myself/leave message? Y N
With whom does the child reside? ____
Reason(s) for seeking therapy?____
Who referred you to me? ____
May I thank them? Y N
Parents Marital Status (Circle) S M D W Sep? How Long?____
Previous Marriage(s)? ___________________
Is your child adopted? Y N At what age?_____________________ Open Adoption? Y N
Previous Counseling? Y N When_______ Duration____ Was it a good experience? Y N
Have you **OR** your child ever been hospitalized for psychological treatment? Y N
Who__________________When______________Where______________________________________
Is your child currently under a physician and/or psychiatrist's care? Y N
Doctors Name____ Phone__________________________
Any medications your child is currently taking? (use back of page if needed)_________
____

Parents Information:
Biological Mother's Name____________________________________Age_________
Birthdate__________Mother's Occupation____
Employer____
Address ____
Biological Father's Name_______________________________________Age_________
Birthdate_________ Father's Occupation____
Employer____
Address ____
Phone numbers if different from above:
Home Phone ( )________________ Work ( )_________________ Cell ( )____________________
Billing Address (If different from above) ____
____
Insurance Co. Name____
Insurance Co. Address____
Insurance Co. Phone #________________________________ ID#____________________________
Group #__________________________________ Plan #_____________________________

Other Children:
Name ___________________ Age ___________ Birthdate ____________
Name ____________________ Age____________ Birthdate_____________
Name ____________________ Age____________ Birthdate ____________
Name ____________________ Age____________ Birthdate_____________
Name ____________________ Age ____________ Birthdate ____________

Others living in home: ____

IN CASE OF EMERGENCY, WHOM SHOULD I NOTIFY:
____

Agreement for Psychotherapy Services

Because therapy often begins in a situation of considerable emotional difficulty, I have prepared these notes so that you will have an understanding of our basic agreement.
Client Name(s): ___________________________________ Date: _______________

Families Counseling Center is owned by Deborah Tucker, MFT Lic #ML 17142.
This office is comprised of several psychotherapists who have joined together for advertising purposes. Each therapist's practice is separate and each therapist is solely and entirely responsible for any liabilities resulting from that practice. As an independent private practitioner, I work closely whenever necessary & appropriate with my professional colleagues at Families Counseling Center. I also employ professional consultations in order to continually improve my professional skills. I meet regularly with my associates and other professionals for case management and consultation. These professionals must also abide by the ethical rules of confidentiality. I will assume I have your permission to discuss your case (**not your name or other identifying information**) with any of my colleagues. If this is not acceptable to you, please let me know.

The Process of Therapy: For children, a therapy session typically lasts 45 minutes, usually beginning on the hour and ending at 15 minutes before the next hour. I encourage you and your child to arrive five to ten minutes early to mentally "switch gears" and take advantage of the entire session time.

Risks and Benefits: Participation in therapy can result in a number of benefits to you and your child, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on the part of the participants. Psychotherapy requires active involvement, honesty and openness in order to change thoughts, feelings, and/or behavior. I will ask for your feedback and views on therapy, as it progresses and will encourage you to respond openly and honestly. During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in experiencing discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. As your child's therapist, I may challenge some assumptions or perceptions, or propose different ways of looking at, thinking about, or handling situations that can cause you to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought your family to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes another family member views a decision that is positive for one family member quite negatively. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. Although I certainly expect that psychotherapy will yield positive or intended results, there is no way to guarantee this. Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit your child. These approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, developmental, sand tray, play therapy, expressive therapy, and/or psychoeducational techniques.

I welcome any questions you may have about the therapy process and practices so please feel free to discuss these with me. I will meet with you regularly about your child's treatment but will need to maintain some degree of confidentiality to promote emotional safety for your child to feel free to be honest.

Cancellations, Financial Terms, and Insurance Coverage:
1. **I require 24 hours notice for a cancellation**. Otherwise you will be a charged my regular session fee for your missed session (charged to you, not your insurance company). You can leave a message on my voice mail (805) 428-6655, any time – any day, 7 days a week. After we discuss this (on or before our first session), I will note any different arrangements here. Fees: ___________________

Initial(s) Here: ____________

2. If you are late, we will meet for the remainder of your scheduled session. If you are more than 15 minutes late and I have not heard from you, I will assume you aren't coming and may leave the office.
3. Telephone time is limited to 10 minutes, beyond which I will bill at my standard rate At 15 minute intervals. Payment will be expected at the next regularly scheduled appointment, or sooner by mail.
4. Additional charges may be incurred for the following: letter writing at client request, court reports or documentation requested by attorneys (authorized by the client), sessions which take place at someplace other than this office, special meetings. Time outside this office is usually charged door to door. Any additional charges will be discussed in advance and agreed upon. I charge for extensive telephone calls (see above). These charges are calculated on my regular hourly fee and in most cases not covered by insurance**.**

Initial(s) Here: ____________

Delinquent Accounts. You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay interest at 1.5% per month, and if it becomes necessary for the account to be referred for collection action, you shall pay the actual balance due plus any collection expenses for 30-50% of any balance owing and any attorney's fees.
You are responsible for obtaining prior authorization for treatment from your insurance carrier. As a courtesy, I will provide you with a statement at the end of each month for you to submit to your insurance. You are responsible for payment for my psychotherapy services at the time of service. Missed appointments are not covered by your insurance and the charges associated with them are your responsibility.

Initial(s) Here: ____________

Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your child's therapy, the possible risks, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your child's condition and their risks and benefits. If your child could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining these treatments, and will gladly do so.

Telephone and Emergency Procedures: If you need to contact me between sessions, please call me at (805) 428-6655 and I will respond at my earliest convenience. If an emergency arises, please indicate it clearly in your message. If you have not heard from me after a few hours, please call again (there are occasions where your message does not reach me due to technical error). If you need to talk to someone right away, or if there is a life-threatening emergency, please call 911 or go to the nearest Emergency Room at a local hospital. Please know that email and text messaging is not considered a confidential method of communication. If you choose to contact me by either of these methods, I cannot assure protection of your confidentiality.

Initial(s) Here:____________

Confidentiality: An important aspect of our therapeutic relationship is confidentiality. Knowing that I will keep our communications private helps to make this a safe place for you to explore, to learn and to grow. Please be aware that the only exceptions to confidentiality are: 1) when you have given written consent for me to share information, 2) when I am required to do so by law, as in cases of suspected child, elder or dependent abuse, or actual or potentially dangerous behavior toward yourself or others, or 3) as required/allowed by HIPPA. Please read the HIPPA form for further clarification of the privacy of your health information and records. **Initial(s) Here: ____________**

Terminating Treatment: Termination from therapy is an important process, which can be of benefit to clients and therapist. This is an important opportunity to reflect on progress, or lack of, and the process of where you are now and where you hope to be going. I encourage my clients to participate with me in this process of finding out what was helpful, as well as, what could have been more helpful. It is your right to terminate therapy at any time. However it is especially important for children to have an adequate time to say goodbye. I do request that you and your child come in to discuss leaving and any feelings that may be associated with the process. If you choose to terminate, I will be glad to provide referrals to qualified professionals. As your therapist, I have the right and duty to terminate therapy under the following circumstances: when I assess that treatment is no longer helpful or beneficial to your child, if I determine that another professional would better serve your needs, if you have not paid for the last two sessions (unless a special arrangement has been made), or if you have failed to show up for your last two sessions without the required 24 hour notice of cancellation. In all cases I will be happy to provide you with resources and referrals as necessary. If there are specific phone numbers you would like me to use to contact you, please note below, and give me directions as to what I may and may not say, directly or in a message:

____

____

If there is another address that you would like statements sent to, please state here:

____

____

If there are phone numbers and/or addresses on the intake form that you would NOT like me to use, please state here:

____

Initial(s) Here: ____________

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY:

Name ________________________ Phone_______________________ Relationship __________________

Consent for Treatment of Minor Child

This is to certify that I give my permission to the therapist listed above for treatment of my child. This treatment may also include individual, family, or group therapy as determined appropriate by therapist. This treatment may include consultations with other associates including Educational Psychologists, Career Counselors, physicians, school staff, or nutritionists.

I understand the purpose of these procedures will be explained to me upon my request, and are outlined above in this document, and that they are subject to my agreement. California State Law mandates the reporting of certain types of child abuse including physical abuse, sexual abuse, and neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency. This treatment may also include referral to other appropriate State and County agencies for further treatment.
I have read the above and agree to contents.

____ ____________________
Parent/Guardians Signature Date

____ ________________
Therapist Signature Date

Client Questionnaire

Client Name_______________________________Date_______________
Why are you here? Describe reasons for seeking help.________________________
____
What help do you expect from therapy?______________________________________
____
Is there anything from past history that may be related to the difficulties your child is experiencing now? (trauma, abuse, substance use, learning difficulties etc....)
____
____
On a scale of 1-10 with 1 being mild and 10 being severe, how would you rate the severity of your child's current difficulties?_________________________________
Is your child depressed at this time? Yes____ No______ Sometimes______
How serious would the depression is? (Scale of 1-10) ________
Has your child had any suicidal thoughts? Yes_____ No_____
Has your child ever attempted suicide? Yes_____No______
Any history of suicide attempts in family? Yes_______ No________
Who? ____
Whom have you presently consulted about your child's present problems?
____
List your child's five worst fears: Worst fear first: 1)_______________
2)______________ 3)_________________ 4)________________
5)_____________________________
What do you consider to be your child's strengths?
____
____
Please check all of the following which are, or have been, problems for your child:
__ Anxiety __Loneliness __Claustrophobia __Parental marital problems
__Shyness __Nightmares __Bowel problems __Lack of appetite

__Tension __Overweight __Can't have fun __Can't keep a job
__Tremors __Child abuse __Hearing noises __Stomach problems
__Insomnia __Nail biting __Money problems __Can't concentrate
__Dizziness __Underweight __Suicidal ideas __Lack of exercise
__Headache __Can't decide __Can't make friends __Eating disorder
__Parenting __Palpitations __Fainting spells __Don't like weekends
__Tiredness __Feel panicky __Unable to relax __Bad home conditions
__Alcohol use __Unemployment __Memory problems __Inferiority feelings
__Drug use __Over-ambitious __School problems __Sexual problems
__Depression __Seeing things __Sexual assault __Sexual abuse
__Neglect __Physical abuse __Sleeping trouble __ADD (ADHD)
__Fearful __Angry __Family Violence
Other problems:____

Please describe your pregnancy with this child:___________________________________
____

Describe your emotional connection with your child in the first year:____________
____
____

Describe your child's health in the first year:___________________________________
____

Any separations? ________________ Please describe_____________________

Physical History- Check any that may apply, past or present:
__Heart problems __Liver problems __Shortness of breath
__Cancer __Immune disease __Hepatitis/jaundice
__Pain or pressure in chest __Severe headaches __Diabetes
__High blood pressure __Head injury __Tuberculosis
__Sexually transmitted disease __Stroke __Alcoholism
__Drug Abuse __Epilepsy/convulsions __Asthma
__Allergies __Seizures __Kidney problems
__Bedwetting/soiling __PMS __Pregnancy
#___ __Abortion #_____Traumatic Event?
Describe____
____

Family of Origin History (parents, siblings, grandparents, aunts, uncles)
Please circle any that apply:
Depression Bipolar (manic/depression) Eating disorder, Alcoholism
Violence Child abuse/sexual abuse, Jail, Drug abuse
Anxiety Attention deficit disorder, Trauma, Schizophrenia
Gambling, Suicide, Pornography, School failure
Alcohol or other substance use in the family – Describe (use back of paper if necessary):
Please indicate past and current use.
Alcohol_______ Amount____________ Frequency____________
Marijuana _____ Amount____________ Frequency____________
Cocaine________ Amount____________ Frequency____________
Methamphetamine ____ Amount____________Frequency_____________
Others____