Child/Adolescent Client Intake Forms

CLIENT INFORMATION

Client's Name: _____ Date of Birth: ____/____/____ Age: _____

Social Security Number: _____-_____-_____

Address: _____

City, State, Zip: _____

Phone 1: _____ Phone 2: _____

May we leave a voicemail message or send a text to Phone 1 and/or Phone 2? _____

_____

How did you hear about Brave Tomorrow? _____

EMERGENCY CONTACT

In case of emergency, who may we notify? _____

Relationship to client: _____ Phone: _____

APPOINTMENT AVAILABILITY

Each session is 45 minutes in length. Please indicate with a check all times you are available for an appointment, and circle the times you prefer:

	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm
Mon.											
Tue.											
Wed.											
Thu.											
Fri.											

brave tomorrow counseling & consulting

Telephone: (404) 620-1551
Fax: (888) 241-9172
Email: office@bravetomorrow.net
Address: 337 South Walnut Street
Statesboro, GA 30458

FAMILY/RELATIONSHIP INFORMATION

Parent/Guardian 1 Name: _____ Relationship: _____

Address: _____

Phone: _____ Phone 2: _____ OK to leave msg? _____

Email: _____

Parent/Guardian 2 Name: _____ Relationship: _____

Address: _____

Phone: _____ Phone 2: _____ OK to leave msg? _____

Email: _____

Parent 3 Name: _____ Relationship: _____

Address: _____

Phone: _____ Phone 2: _____ OK to leave msg? _____

Email: _____

Parent 4 Name: _____ Relationship: _____

Address: _____

Phone: _____ Phone 2: _____ OK to leave msg? _____

Email: _____

Who has LEGAL custody of the child? _____

If parents have joint custody, who has the medical tiebreaker? _____

If parents are divorced, our office needs a copy of the court custody order showing primary custody or medical tiebreaker, or the consent of both parents

SIblings:

Name	Age	Full/Half/Step/Other	Lives With?

Any other people in the home:

Name	Age	Relationship

Have you been involved with Department of Family and Children's Services (DFCS) *in the past*? If so, please explain: _____

Are you *currently* involved with DFCS? If so, please explain: _____

Please list any significant family issues or concerns at this time: _____

SUBSTANCE USE

Does the client have any significant substance use history – either current or past (this can include alcohol, marijuana or other illegal substances, or use of prescription drugs without a prescription)? If so, please explain.

Has the client ever been in a support group (AA, NA, Celebrate Recovery) for alcohol or drug use (please explain)? _____

Has the client been in an outpatient treatment program for alcohol or drug use, DUI classes, or other drug classes (please explain)? _____

Has the client ever been hospitalized or in an inpatient treatment program for alcohol or drug use (please explain)? _____

LEGAL INVOLVEMENT

In the past, has the client been convicted of a crime (misdemeanor or felony)? If yes, please explain: _____

Is the client currently involved with the legal system/department of juvenile justice in any way? (Awaiting trial, probation, parole, etc.)? If yes, please explain: _____

HEALTH AND MEDICAL

Primary Care Physician/Pediatrician: _____ Phone: _____

Please list any medical problems: _____

Has the client ever seen a Psychiatrist, Psychologist, or any other mental health provider? _____

If yes, please list name of provider and focus of treatment: _____

Previous Mental Health diagnoses: _____

Please list any current medications: _____

_____

Has the client ever been hospitalized for psychiatric reasons? If yes, please complete:

Hospital	Month/Year	Reason

MEDICAL HISTORY

Please circle::

Overall health has been	VERY GOOD	GOOD	FAIR	POOR	VERY POOR
Hearing	VERY GOOD	GOOD	FAIR	POOR	VERY POOR
Vision	VERY GOOD	GOOD	FAIR	POOR	VERY POOR
Gross motor coordination (running, walking, etc)	VERY GOOD	GOOD	FAIR	POOR	VERY POOR
Fine motor coordination (writing, grasping, etc)	VERY GOOD	GOOD	FAIR	POOR	VERY POOR
Sleeping	VERY GOOD	GOOD	FAIR	POOR	VERY POOR
Eating	VERY GOOD	GOOD	FAIR	POOR	VERY POOR

Chronic health problems: _____

Hospitalizations for medical reasons: _____

Past medications: _____

Current medications: _____

Illnesses or injuries (circle any that apply):

Mumps	Chicken Pox	Whooping Cough	Measles	Pneumonia	Scarlet Fever
Encaphalitis	Lead Poisoning	Chronic Ear Infections	Seizures	High Fevers	Debydration
Broken Bones	Severe Lacerations	Severe Bruises	Head Injury with Loss of Consciousness	Eye Injury	Consussion

ADACEMICS/SCHOOL PERFORMANCE

Grade level	Performance/Grades	Subject Difficulty	Emotional/Behavioral Difficulty
Daycare			
Pre-K/ Kindergarten			
Grades 1-3			

Grades 4-5			
Grades 6-8			
Grades 9-12			
College/ Tech School			

Has the client repeated any grades? _____

Has the client attended summer school? _____

Academic diagnosis? (learning disabilities, etc) _____

Does the child have an IEP or 504 Plan? _____

Speech or Language Therapy? _____

Occupational Therapy? _____

Gifted programming? _____

Detention, ISS, Expulsion? _____

Strongest academic subject(s)? _____

Weakest academic subject(s)? _____

DEVELOPMENTAL HISTORY

PREGNANCY

Birth schedule/weight: How many weeks at delivery? _____ Birth weight: _____

	Yes/No	Explanation
Fetal distress		
Mother on medications		
Tobacco/Alcohol/Drug use		
Labor complications (including induction or C-section)		
Infant health problems		

INFANT HEALTH AND DEVELOPMENT

	Yes/No	Explanation
Early feeding problems		
Colicky		
Sleeping difficulties		
Eating difficulties		
Illness/health problems		
Alert and responsive		

Overall, the client had a(n) (LOW, MODERATE/AVERAGE, HIGH) activity level (circle one).

Overall, the client was a(n) (EASY, AVERAGE, CHALLENGING, VERY DIFFICULT) baby.

SOCIAL/EMOTIONAL HISTORY

	Yes/No	Explanation
Does the client get along well with peers?		
Does the client get along well with teachers?		
Does the client show affection easily?		
Does the client have best friend(s)?		
Is the client sexually active?		
Hs the client ever witnessed violence?		
Has the client ever suffered emotional abuse?		
Has the client ever suffered physical abuse?		
Has the client ever suffered sexual abuse?		

What are the client's strengths? _____

What are the client's interests/hobbies? _____

What things do you and the client enjoy doing together? _____

MENTAL STATUS/SYMPTOM CHECKLIST

Please circle any of the following moods or behaviors that describe the client *lately*:

Sad	Anxious	Depressed	Frightened	Guilty	Angry	Ashamed	Aggressive	Worthless
Extreme Ups	Extreme Downs	Resentful	Tearful	Irritable	Confused	Jealous	Hopeless	Annoyed

Has the client ever **considered or attempted** suicide in connection with current or past problems? If yes, please give a brief description with dates: _____

Has the client ever **considered or attempted** to hurt or kill someone else in connection with current or past problems? If yes, please explain: _____

Has the client engaged in self-harming behaviors (cutting, burning, etc) in connection with current or past problems? If yes, please explain: _____

Please check the appropriate box:

Inattention	Never	Sometimes	Often	Always
Fails to give close attention to details or makes mistakes in schoolwork, work or other activities				
Difficulty sustaining attention in tasks or play activities				
Does not seem to listen when spoken to directly				
Does not follow through on instructions and fails to finish school work, chores, or duties in the workplace (not due to oppositional behavior)				
Difficulty organizing tasks and activities				
Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort, such as school or homework				
Loses things necessary for tasks or activities, such as toys, books, or tools				
Easily distracted by noises or actions going on				
Forgetful in daily activities				
Hyperactivity/Impulsivity	**Never**	**Sometimes**	**Often**	**Always**
Fidgets with hands or feet or squirms in seat				
Leaves seat in classroom or in other situations where inappropriate				
Runs about or climbs excessively inappropriately or excessive restlessness				
Difficulty playing or engaging in leisure activities quietly				
Is “on the go” or acts as if “driven by a motor”				
Talks excessively				
Blurts out answers before questions have been completed				
Difficulty awaiting turn				
Interrupts or intrudes on others’ conversations or activities.				
Disruptive Behaviors	**Never**	**Sometimes**	**Often**	**Always**
Loses temper				
Argues with adults				
Actively defies or refuses adult requests or rules				
Deliberately does things that annoy other people				
Blames others for own mistakes				
Is touchy or easily annoyed by others				
Is angry or resentful				
Is spiteful or vindictive				
Swears or uses obscene language				
Bullies, threatens, or intimidates others				
Initiates physical fights				
Has used a weapon that can cause harm				

Has been physically cruel to people or animals				
Has stolen while confronting a victim				
Has forced someone else into sexual activity				
Has deliberately engaged in fire setting				
Has deliberately destroyed others' property				
Lies to obtain favors or to avoid obligations				
Mood and Anxiety	**Never**	**Sometimes**	**Often**	**Always**
Depressed or irritable mood for a majority of the day				
Diminished interest or pleasure in activities that he/she used to enjoy				
Significant weight loss or decrease in appetite				
Significant weight gain or increase in appetite				
Feelings of worthlessness or guilt				
Recurrent thoughts of death or suicide, or a suicide attempt or specific plan for suicide				
Explosive temper or marked mood swings with little reason				
Excessive anxiety or worry				
Recurrent distressing thoughts or dreams from a traumatic event				
Brief periods of intense fear or discomfort, with increased heart rate, sweating, trembling, shortness of breath, dizziness, or fear of losing control				
Other symptoms	**Never**	**Sometimes**	**Often**	**Always**
Motor or vocal tics				
Little or no interest in peers				
Initiates or terminates social interactions inappropriately				
Excessive reaction to changes in routine				
Bizarre ideas or thoughts				
Hallucinations (seeing, hearing, feeling things that are not there)				
Relentless pursuit of a thin body, despite hunger and threat of starvation				
Periods of binge eating				
Periods of purging (inducing vomiting, using laxatives to induce bowel movements, "crash" diets)				

COUNSELING CONCERNS, RESOURCES, AND GOALS

What are the concerns that bring the client to counseling?

1. _____
2. _____
3. _____
4. _____
5. _____

What have you previously tried in order to resolve these issues (religious counseling, talking with family/friends, medication without counseling, other counselors)? Were any of these helpful? _____

_____

_____

_____

Who do you consider the client's support system? _____

_____

How does the client deal with stress right now? _____

_____

What are the client's strengths? What does the client do well? _____

_____

GOALS ARE VERY IMPORTANT IN COUNSELING. They provide the client and the therapist with a focus and a direction for therapy sessions. Please list the goals that you want to address and reach in counseling.

1. _____
2. _____
3. _____
4. _____
5. _____

By signing below, I confirm that the above information is true and correct. I understand that I have the right to agree to, or to refuse, mental health services from Brave Tomorrow Counseling and Consulting.

Client name (printed): _____ Date: _____

Client signature: _____

Parent/Guardian signature: _____

Counselor signature: _____ Date: _____

PLEASE READ THE FOLLOWING CAREFULLY
I understand that I am responsible for my own and/or my child's fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.
Client/Guardian Signature: _____ Date: _____

I understand that, as a courtesy to its clients, Brave Tomorrow utilizes a reminder system for appointments. It is my responsibility to keep updated email and cell phone information on file. I understand that I will be charged for late cancel (less than 24 hours) or missed appointments WITH OR WITHOUT a reminder notification. It is MY responsibility to keep track of my appointments.
Client/Guardian Signature: _____ Date: _____

I understand that I must be committed to attend my own sessions or bring my child to sessions on a consistent basis, on time, in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform the therapist of my decision prior to my last visit. If my therapist believes that I or my child can receive more effective treatment elsewhere, I will be given referrals. I understand that I or my child may not attend a session if under the influence of alcohol or drugs, or in the possession of a dangerous weapon. My signature below indicates my desire and consent to receive mental health services for myself or my child from Brave Tomorrow Counseling and Consulting.
Client/Guardian Signature: _____ Date: _____

It is in your best interest to know that therapists at Brave Tomorrow are not considered Forensic Psychologists and conducting witness/testimonial services or assessments are not in our area of expertise. If you have a suspicion that your case will be going to court or you need therapist testimony, please let us know and we will provide you with an appropriate referral source that can better meet your needs. If you require services for court, we recommend that you hire another mental health professional for that purpose. Should you subpoena a Brave Tomorrow therapist as a factual case witness or involve them in court related processes, you agree to pay out of pocket for the therapist's time involved. Court-related expenses cannot be billed to insurance.
Client/Guardian Signature: _____ Date: _____

I understand that, as the parent/guardian of a minor, I legally have access to all information regarding my child's treatment at Brave Tomorrow. However, I also understand that some measure of trust and confidentiality is necessary in order for my child's treatment to be as effective as possible. Brave Tomorrow has my full consent to treat my child/adolescent, and I understand that the counselor will notify me of any significant information and will update me regularly regarding my child's treatment.
Client/Guardian Signature: _____ Date: _____

INSURANCE INFORMATION

Primary Insurance

Company Name _____

Please Circle: HMO PPO Other Policy ID Number: _____

Group Number: _____ Behavioral Health Phone: _____

Name of Insured: _____ D.O.B.:_____

Relationship to Client: _____

Secondary Insurance Policy

Company Name _____

Please Circle: HMO PPO Other Policy ID Number: _____

Group Number: _____ Behavioral Health Phone: _____

Name of Insured: _____ D.O.B.:_____

Relationship to Client: _____

(ATTACH COPIES OF CARDS BELOW)

Client Agreement to Pay for Service

I agree to pay all charges for the services my child receives. If I use insurance to cover some or all of my child's counseling at Brave Tomorrow, I agree to pay any amounts that my insurance carrier does not pay. These may include (but are not limited to) services and charges determined by my insurance carrier not to be medically necessary, and/or services and charges not covered by my insurance plan. If I incur a charge for a missed or late-canceled appointment, I understand that I will be responsible for payment of that charge.

Client Signature: _____ Date: _____

SUMMARY OF CLIENT RIGHTS

When you receive mental health services, your rights are protected by the Health Insurance Portability and Accountability Act (HIPAA). Listed below is a simplified outline of those rights. The Notice of Privacy Practices describe any limitation to these rights and other provisions that may apply and should be consulted when there is a dispute or questions arise regarding any of these rights.

Your rights include:

- The right to receive care suited to your needs.
- The right to receive services that respect your dignity, and protect your health and safety.
- The right to know the names and positions of those involved in services planning and implementation process.
- The right to be informed of the benefits and risks of treatment.
- The right to participate in planning your own program.
- The right to refuse service, unless a therapist feels that refusal would be unsafe for you or others.
- The right to receive a copy of the Notice of Privacy Practices.
- The right to inspect and copy your records.
- The right to request amendment to your records.
- The right to request restriction or limitation on the medical information we use or disclose about you.
- The right to request how and where you may be contacted.
- The right to request on accounting of all disclosures we make about you to other persons or agencies.
- The right to exercise all civil, political, personal, and property rights to which you are entitled as a citizen.
- The right to remain free from physical restraints or time-out procedures unless such measures are required for providing effective treatment, or protecting the safety of you or others.
- The right to be free of physical or verbal abuse.
- The right to file a complaint if you think any of these rights have been restricted or denied.

You must be provided with a Notice of Privacy Practices that provides detailed information regarding your rights under HIPPA.

The client has had an opportunity to read, or have read to him/her, the above form to ask questions regarding the data contained therein and had signed in the person's presence.

Client Name: _____

Parent/Guardian Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

SUMMARY OF CLIENT RIGHTS (CLIENT COPY)

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----------THIS COPY IS YOURS TO KEEP----------