Tree of Life Counseling
RESTORING THE LIFE WITHIN YOU

# Child-Adolescent Intake Form

*The following form will become part of your child's confidential record. Please answer each question as completely and as carefully as you can.*

Child's Name:_____ Date of Birth: _____ Age: _____ Sex:_____

Street Address: _____ City & State: _____ Zip:_____

Grade in School:_____ School/daycare Attending:_____

Parent/Legal Guardian:_____

**May we contact you and/or leave messages via…?**

☐ Parent Cell Phone:_____ ☐My Phone: _____

☐ Parent Email: _____ ☐My Email: _____

☐ Other form of contact (specify): _____

## *Personal Information*

Describe any physical problems your child has that require medication or physical care: _____

_____

How long ago was your child's last physical? _____

Is your child currently receiving medical treatment? Yes ❑ No ❑

If yes, please explain:

Is your child currently taking any prescription medications? Yes ❑ No ❑

If yes, please list:

Any family psychiatric history (e.g., depression, anxiety, substance abuse)? Yes ❑ No ❑

If yes, please explain:_____

How often does your child consume non-prescription drugs and/or alcohol? _____ If appropriate: What is his/her highest use of any substance within the past 6 months? _____

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*SPIRITUAL BACKGROUND (Optional)*

Is your child a part of a local faith community? Yes ❑ No ❑ If so, which one? _____

How would you rate your child's current interest in spiritual growth at this time?

1 2 3 4 5 6 7 8 9 10

◀ ---------- ▶

No interest Not sure Very interested

*Problem Areas*

Place a check mark next to each item that identifies an area of concern to your child. Place two checks next to those that are most important. Please circle or underline to clarify your choice or add additional comments.

- ☐ My child has no problems or concerns
- ☐ Abuse (physical, sexual, emotional) or neglect
- ☐ Aggression, violence, threats
- ☐ Anger / Frustration, hostility, arguing, irritability, temper problems
- ☐ Anxiety, nervousness, panic, tension
- ☐ Chest pain
- ☐ Confusion, thought or memory problems
- ☐ Depression, low mood, sadness, crying
- ☐ Difficulty trusting, suspiciousness
- ☐ Drug or alcohol abuse
- ☐ Easily agitated / annoyed
- ☐ Eating difficulties-overeating, under eating, appetite disturbance, vomiting, weight, diet
- ☐ Education/academics
- ☐ Emptiness
- ☐ Failure
- ☐ Fearfulness or phobias
- ☐ Goals, choices
- ☐ Grieving (mourning, deaths, losses, divorce)
- ☐ Guilt
- ☐ Heart pounding / racing
- ☐ Hopelessness
- ☐ Impulsiveness, lack of control
- ☐ Irresponsibility
- ☐ Isolation / withdrawal
- ☐ Judgment problems, risk taking
- ☐ Loneliness
- ☐ Low energy/motivation or fatigue
- ☐ Low self-esteem, inferiority feelings
- ☐ Menstrual problems, PMS
- ☐ Mood swings
- ☐ Nervousness
- ☐ Obsessive thoughts / compulsive behavior
- ☐ Oversensitivity to rejection/criticism, shyness
- ☐ Perfectionism
- ☐ Physical problems, headaches, other pains
- ☐ Poor concentration, attention, distractibility
- ☐ Problems with parents
- ☐ Problems with sibling(s)
- ☐ Sleep disturbances (too much/little, insomnia)
- ☐ Social/interpersonal conflicts or problems
- ☐ Stress, tension
- ☐ Substance abuse by another person
- ☐ Thoughts of hurting others
- ☐ Thoughts of hurting self
- ☐ Thoughts of suicide
- ☐ Trauma
- ☐ Trembling / shaking
- ☐ Unpleasant thoughts won't go away
- ☐ Worthlessness

*Other:*_____

_____

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# Informed Consent and Description of Fees and Services

Counseling is a cooperative venture with responsibility resting on both therapist and client. Please carefully read the information below.
If you have any questions, your therapist will be happy to discuss them with you.

CLIENT RIGHTS: You have the right to decide not to enter therapy and may end therapy at any time. You have the right to ask questions to your therapist at any time regarding the treatment you are being provided and to receive answers that are clear and satisfactory to you. You have the right not to allow the use of any therapy intervention/technique. You have the right to confidentiality in treatment with certain exceptions (see below). You have the right to review your records and to receive a copy of your file.

LIMITS OF SERVICE AND ASSUMPTION OF RISKS: Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

LIMITS TO CONFIDENTIALITY: In general, communications between client and therapist are confidential. Such information will not be released to anyone, including other agencies, without your written consent. There are some limitations, however, to confidentiality. As mandated reporters, Georgia state law requires that therapists report to the appropriate authorities any suspected abuse (including sexual abuse, physical abuse, and neglect) of a minor, older adult, or disabled/dependent adult. Mandated reporters are also required to report imminent risk of suicide and threat(s) of homicide. In addition, if a therapist receives a subpoena or court order to testify in a legal matter in which a client is involved, the therapist must respond. In the event a medical emergency occurs in the therapy office, emergency medical professionals will be contacted immediately. If you choose to use your health insurance to cover part or all the cost of treatment, Tree of Life Counseling must reveal: A) The fact that you are a client; B) The primary diagnosis for which you are receiving treatment.

SESSION LENGTH: The therapeutic session lasts 45-52 minutes. The additional time is used for scheduling the next appointment, receipt of payment and charting of your session.

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CANCELLATIONS: Regular attendance will produce the maximum possible benefits. If you must cancel, please call your therapist at (352)-284-4379 and leave a message on the voice mail at least 24 hours in advance of your scheduled appointment. A missed appointment fee will be charged for cancellations received less than 24 hours in advance.

LATE/MISSED APPOINTMENTS: Therapists are scheduled to see clients hourly. Therefore, it is necessary to be prompt for your session. If a client chooses to arrive late, only the remainder of the scheduled session time will be utilized and the client will be billed for the time spent in session. If a client is more than 15 minutes late, the appointment will be rescheduled, and the client will be charged a missed appointment fee. If a client fails to attend an appointment, including a first appointment, a credit card must be placed on file before another appointment is made. Clients who fail to attend their second intake appointment will be charged a missed appointment fee.

TELEPHONE CALLS: Your therapist will provide you with a contact number where you can leave a confidential message for him/her. When calling, please leave your name and telephone number (even if we already have it on file). Your call will be returned in a timely manner.

EMERGENCY PROCEDURES: In order to ensure prompt attention during an emergency situation in which you are unable to contact your therapist, you will need to contact the Northeast Georgia Medical Center at (770) 535-3553, where emergency mental health personnel are available 24 hours a day. Please dial 911 for immediate assistance.

PAYMENT: Payment is due on the date of your appointment and can be made via cash, check or credit card. Please make all checks payable to Daniel Mariney. There is a fee of $25 for any check returned due to insufficient funds. Fees for services are as follows: Masters Level Clinician- $160/intake, $135/session for 1 hour and $110/session for 45 minutes. A $25 fee will be added onto any mobile or at home sessions.


By signing below, I consent to receiving treatment as described in this form, accept the forms of communication noted above, acknowledge that this form and its contents will become a part of my medical record, and agree with these terms and conditions:

1) _____ is the amount I am expected to pay per session.
2) $50 is the missed appointment fee I have agreed to pay, and I understand that this will not be paid by insurance but is my responsibility.
3) By providing a credit card for payment, I am consenting to the information being stored securely and to it being used to cover the cost of treatment including missed appointments unless other arrangements are made at the time of service.
4) I have been offered and/or reviewed a copy of Tree of Life Counseling's Notice of Privacy Practices.
5) I have been informed that Tree of Life Counseling is in compliance with the Health Information Portability and Accountability Act (HIPAA)

Client Signature:_____Date:_____
*Signature of the custodial parent or guardian is required for clients under 18 years of age.

Staff Therapist:_____ Date:_____