Child Intake Form

Child's First Name: _____ Middle Initial: _____
Child's Last Name: _____

Child's Gender: ___Male _____Female
Child's DOB: _____ _____ _____ Child's Age: _____
(Month) (Day) (Year)

Parent / Guardian Name: _____
Parent / Guardian Name: _____

Contact Information:

Address of Primary Care Parent: _____
City: _____ State: _____ Zip Code: _____

Telephone:	Preferred
(H) _____	☐
(W) _____	☐
(C) _____	☐

E-mail address: _____

Demographic Data:

Child's Ethnicity: _____
Child's School: _____
Child's Grade Level: _____

Name of Pediatrician: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Church Attending: _____
How Long: _____

Referral Source:
Check the appropriate box

Referred by: ☐ Doctor ☐ Pastor ☐ Former Client ☐ Website ☐ Insurance
☐ Other _____

Child's Developmental Background

(place a check by all that apply)

0-3 Months Old
__Smiles Responsively
__Turns head to sound
__Holds head up
__Grasps rattle
__Holds hands together
__Reaches for people/objects

9-15 Months Old
__Bangs 2 blocks together
__Drinks from a cup
__Pulls self to stand
__Indicates wants
__Imitates sounds/words
__Begins to walk

3 to 4 Years Old
__Dresses w/o supervision
__Imitates
__Recognizes colors
__Comprehends tired, cold, hungry
__Can jump rope
__Print first name

7 to 9 Years Old
__Can throw a ball
__Can print sentences

__Recognizes value of coins
__Has friends
__Reads
__Begins to accept responsibility for

12 to 15 Years Old
__Peer group is very important
__Privacy is very important
__Tires easily
__Interest in opposite sex
__Recognizes consequences of behaviors
__Uses creative thought processes

3-9 Months Old
__Laughs and squeals
__Transfers toy from hand to hand
__Plays peek-a-boo
__Sits w/o support
__Feeds self crackers
__Imitates speech sounds

16 Months to 2 Years Old
__Scribbles
__Uses spoon
__Removes clothing
__Runs well
__Talks in short sentences
__Plays alongside other children

5 to 6 Years Old
__Able to skip
__Plays a game following the rules
__Asks what words mean
__Draws a person
__Ties shoes
__Uses sentences well

9 to 12 Years Old
__Writes in cursive
__Able to establish close peer friends
__Participates in discussions
__Argues
__Uses both hands independently

Medical History:

Current physical complaints / problems: (indicate when complaint started)

_____
_____
_____
_____

Past serious medical problems: (give dates / any weight loss or gain, any head trauma or seizures)

_____
_____
_____

Medication Usage:

Name of Medication(s)_____
Start date: _____
Dosage: _____
Frequency of use: _____
Side effects _____
Beneficial: ___Yes ___No

Name of Medication(s)_____
Start date: _____
Dosage: _____
Frequency of use: _____
Side effects _____
Beneficial: ___Yes ___No

Daily Activities at Home and School:

- Does the child follow a certain routine? If so please describe.

  _____
  _____
  _____
  _____
  _____

- What activities require assistance:

  _____
  _____
  _____
  _____

- Child's bedtime? _____ Naps: _____

(Note: Complete only for children 5 y.o. and older)

- Does the child complete his / her assignments?: __Yes __No
- Does the child have trouble with teachers? __Yes __No
- Does the child socialize with a group of friends? __Yes __No

Primary Problem / Complaint: (main reason child is coming for counseling)

_____

_____

_____

Secondary Problems / Complaints:

_____

_____

_____

Child's Symptoms:
Check all that apply

__Sleeping too much
__Sleeping too little
__Nightmares
__Eating too much or too little
__Weight loss or gain
__Sadness
__Depressed / down / hopeless
__Loss of interest in activities
__Low self-esteem
__Anxious / nervous / on edge
__Fearfulness
__Trouble relaxing
__Easily annoyed or irritable
__Headaches
__Hyper / can't sit still / restless
__Worrying about a lot of things
__Few or no social relationships
__Stressed
__Poor concentration
__Anger issues
__Behavior problems
__Harming self
__Harming others
__Destroying property
__Sexual abuse victim
__Physical abuse victim
__Emotional abuse victim
__Bullying others
__Victim of bullying
__Substance abuse
__Stomachaches
__Difficulty focusing on work
__Grief or loss
__Does not get along with others

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Consent for Treatment
and Limits of Liability

Limits of Services 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 of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under 18) _____ Date _____

Informed Consent for Treatment

Client Agreement:

- I am aware that the practice of psychotherapy is not an exact science and that successful outcomes of counseling cannot be guaranteed and no promises about the results of treatment have been stated to me.
- The risks, benefits, side-effects, and alternative of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.
- I understand that I need to provide accurate information about myself and my concerns to my therapist so that I can receive effective treatment. I also agree to play an active role in my treatment.
- I understand that I may end treatment at any time. I agree to inform my therapist of my termination and the reasons why.
- I understand that all information share in the counseling sessions is confidential. However, I am aware that confidentiality can be broken in the case that I could harm myself, someone else or if a court of law requires the therapist to break confidentiality. I understand that my therapist may be supervised and the supervisor may have knowledge of my case except for my name.

I accept the above conditions with my Counselor(s) and agree to abide by them.

Confidentiality

CONFIDENTIALITY AND PRIVILEGED COMMUNICATION REMAIN RIGHTS OF ALL COUNSELORS. HOWEVER, SOME COURTS HAVE HELD THAT IF AN INDIVIDUAL INTENDS TO TAKE HARMFUL, DANGEROUS, OR CRIMINAL ACTION AGAINST ANOTHER HUMAN BEING, OR ONESELF, IT IS THE COUNSELOR'S DUTY TO WARN APPROPRIATE AUTHORITIES OF SUCH INTENTIONS. COUNSELORS ARE MANDATED BY INDIANA LAW TO REPORT ANY INCIDENCES OF "REASONABLE SUSPECTED CHILD ABUSE" (Physical or sexual). Thus, any "reasonably suspected child abuse (physical or sexual)" will be reported to the proper authorities. *Prior to informing any client who should be warned, the counselor(s) will make a concerted effort to share the intention of these laws with the client.*

I have read the above statements and understand the counselor's and supervisor's social and ethical responsibility to warn when harmful, dangerous, or criminal action is evident. I further understand the counselor's legal responsibility to notify the proper authorities in cases of "reasonably suspected child abuse" whether physical or sexual.

Name of client (print)	Date
Client's Signature	If under 18, Parent or Guardian
Relationship to Client Signature	Date
Counselor Signature	Date

New Beginning Christian Counseling

5505 Foxridge Drive, Suite 102, Mission, KS 66202

WAIVER OF MEDICAL/PSYCHIATRIC CONSULTATION

I understand that under the provisions of KSA 65-6404 (b) (3) my therapist(s) is/are required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that is causing or contributing to any observed symptoms of a mental disorder in either myself or my minor child(ren) listed below:

Name of Minor child	*Name of Minor child*
Name of Minor child	*Name of Minor child*

In the event that I or my minor child(ren) do not have a primary care physician or psychiatrist, I acknowledge that my student counselor(s) has/have recommended that *I seek medical consultation.*

By signing below I am indicating that I waive my right to such consultation and that I do not wish for my student counselor to contact my(our) physician(s). I am also aware that this waiver will become part of my client record.

X Client Signature	Date	Client Signature	Date
Client Signature	Date	Client Signature	Date
Client Signature	Date	*Client Signature*	*Date*

New Beginning Christian Counseling

CONFIDENTIALITY

The information clients share in therapy and all documents relating to therapy services are kept confidential, unless the client requests in writing that the records be released. Some specific confidential information may be disclosed for the purpose of professional consultation/supervision and guidance in treatment, or when mandated by law. Your Therapist, Sherrie Pucket, is under the direct supervision of Craig Waddle, LCPC, of CrossPointe Counseling Center. Kansas law mandates that confidentiality be broken if you are found to be a clear and imminent danger to self or others, if you report current abuse of a child or dependent adult, or if your therapist receives a court order to release your records.
Please allow Craig Waddle full access to your client file for the purpose of guiding your counseling.

Client Signature _____ Date _____

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INFORMED CONSENT & THERAPY CONTRACT

We feel it is important that you are fully informed about the therapy services you will be receiving before deciding to begin therapy. Your signature below indicates that you have received, read, and understand the practice policies of this therapy site.

1. I understand that Sherrie Pucket is bound by the Code of Ethics set forth by the American Counseling Association (ACA), and I can request a copy of these ethics at any time.
2. I understand the confidentiality policies concerning case consultation. I also understand that, according to Kansas Law, Sherrie Pucket has an obligation 1) to warn others of life threatening concerns should it become necessary, 2) to notify appropriate state agencies of any suspicion of child or dependent adult abuse and, 3) to provide information in legal cases when under court order, and 4) to release information from my file when I request this using a written release.
3. I understand that there can be risks and benefits associated with therapy and have discussed those with Sherrie Pucket. I also understand that no promises have been made to me as to the results of treatment or of any procedures provided by Sherrie Pucket.
4. I understand that I may leave therapy at any time and agree to discuss the termination of therapy with Sherrie Pucket at a regular therapy session rather than by phone.
5. I understand that, under Kansas Law, Sherrie Pucket is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to any observed symptoms of a mental disorder. In order to complete such a consultation, Sherrie Pucket will request that I complete a Release of Information form. I also understand that I may waive this consultation, in writing, and that my therapist will discuss this process with me at any time if I so request.
6. I understand the financial policies of this therapy site and agree to pay $_____ for therapy at the beginning of each session. I understand that if I miss a scheduled session for any reason except an emergency I am still responsible for the fee.
7. I have received the client information sheet which informs me of my rights and other pertinent information. This information has been explained to me and any questions answered by Sherrie Pucket. _____ (Client Initials)

My signature below indicates that I give my full informed consent to receive therapy services from Sherrie Pucket.

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____MI ___
DOB:__/__/____
Client Address

_____
Client Home Phone: _____ Cell/Work Phone:

_____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____
Phone: _____
Address: _____

Date of Authorization: ___/___/_____
Authorization to expire on ___/___/_____ or upon the happening of the following event: _____

Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)

□ My entire mental health record

□ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)

□ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

□ Other: _____

Purpose of Information Release:

□ Further mental health care
□ Applying for insurance
□ At the request of the individual
□ Payment of insurance claim
□ Vocational rehab, evaluation
□ Other (specify): _____
□ Legal investigation
□ Disability determination

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

If signed by a personal representative:

(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: □ minor □ incompetent □ disabled □ deceased

Legal authority: □ parent □ legal guardian □ representative of deceased

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.