Adolescent Intake Form (to be completed by minor)

Full Name: ________________________________ Name you prefer: ___________________

Address: _________________________________ City: ________________ Zip: ______

Sex: ☐ Male ☐ Female Birth Date: ___________________ Age:_________ Grade: _____

Home Phone _______________ Cell Phone ______________ Email_____________________

Name of Parent/Guardian: ____

Who are you presently living with? ____

School: __________________________ Job (*if none, leave blank)*: ______________________

Hobbies: ____

Do you believe in God? ☐ Yes ☐ No Religious preference_________________________

FILL IN THE BLANK: God is ____

Please describe why you are coming to counseling (i.e. what are the problem(s) that you want help with)?:____

____

PROBLEMS CHECKLIST

Please rate each issue: 1 = Major Problem 2 = Sometimes a Problem 3 = Never a Problem

_____ Feeling accepted by my peers

_____ Learning how to trust others

_____ Getting a clear sense of what I value

_____ Worrying about whether I'm normal

_____ Excessive worry or anxiety

_____ Dealing with my alcohol or drug abuse

_____ Never eating/eating too much and vomiting to control weight

_____ Trying to decide on a career

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

_____ Dealing with sexual feelings and/or problems

_____ Getting along with my parents or other family members

_____ Feeling bad about the way I look/my body

Are there any other problems or concerns you would like to address? ____________________

____

____

CONFIDENTIAL CLIENT INFORMATION FORM—MINOR CLIENT

To be filled out by parent/guardian of minor.

GENERAL INFORMATION

Date: ___________________________ Referred by:__________________________________

May I have your permission to thank this person for your referral? ☐ Yes ☐ No

Full Name of Child/Adolescent: ____

Name of Parent/Guardian: □ Mr. □ Mrs. □ Miss □ Dr. □ Rev. ___________________________

Name You Prefer: ________________________ Name Child Prefers: ________________________

Relationship to Child: ____

Your Age/Date of Birth: ___________________ Child's Age/Date of Birth: ____________________

CONTACT INFORMATION

Address: ____ City: _____________ Zip:_________

May I send mail here? ☐ Yes ☐ No

Home Phone: _______________________________________ Leave message here? ☐ Yes ☐ No

Cell Phone: ____ Leave message here? ☐ Yes ☐ No

Work Phone: ____ Leave message here? ☐ Yes ☐ No

E-mail address:____ Contact you here? ☐ Yes ☐ No

IN CASE OF EMERGENCY, CONTACT:

Name: ____Relationship: ____________________

Home phone: _______________ Work phone: _________________ Cell phone: _______________

EMPLOYMENT INFORMATION OF ADULT/PARENT

Employer:____________________________________ How long have you been here:___________

Occupation:__________________________________ Avg. hours worked per week _____________

RELATIONAL STATUS OF ADULT/PARENT

☐ Single ☐ Dating ☐ Engaged ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Relational Status? ☐ Yes ☐ No If no, briefly explain: _____

____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: ___

If Separated or Divorced, How Long: ______________ If Widowed, How Long: ____________

Partner/Spouse's name:____ Age _______________

How Long Have You Known Your Partner: ________ Partner's/Spouses Sex: □ Male □ Female

Partner's Occupation: ___________________________ Avg Hrs Worked Per Week: _________

With whom does the child/adolescent currently live? (*Check all that apply*)

☐ Parent(s) ☐ Grandparent(s) ☐ Alone ☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate

☐ Other:_____________________________

List child's mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon their life.

Name	Current age or year of death	Relationship to child	Give 2-3 words to describe this person

MEDICAL INFORMATION OF CHILD

Primary Physician: ______________________________________ Phone: (____) ____________

Address: ______________________________ City: ______________ Zip: _______________

Is Child Currently Receiving Medical Treatment: □ Yes □ No. If Yes, Please Specify:

____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments Child Has Had (Use Back if Necessary): ____

____

List All Current Medications Child is Taking, Including those Seldom Used or Take Only as Needed (Use Back if Necessary):

Medication: ____ Dosage: _______________

□ Improves □ Prevents □ Controls: ____

Medication: ____ Dosage: _______________

□ Improves □ Prevents □ Controls: ____

Is Child Taking these Medication(s) According to Doctor's Recommendations: □ Yes □ No

If No, Briefly Explain: ____

PHYSIOLOGICAL SYMPTOMS NOTED CONCERNING CHILD

Please Check Any of the Following Physiological Symptoms/Sensations that Apply Presently, or in the Recent Past:

Present	Past	Symptom	Present	Past	Symptom
❑	❑	Headaches	❑	❑	Weakness
❑	❑	Dizziness	❑	❑	Tension
❑	❑	Stomach Trouble	❑	❑	Rapid Heart Rate
❑	❑	Visual Trouble	❑	❑	Difficulty Breathing
❑	❑	Sleep Trouble	❑	❑	Intestinal Trouble
❑	❑	Trouble Relaxing	❑	❑	Hearing Noises

Present	Past		Present	Past	
❑	❑	Change in Appetite	❑	❑	Hearing Voices
❑	❑	Tiredness	❑	❑	Seeing Things
❑	❑	Pain	❑	❑	Other

Child's height: ___________ Child's weight: _______ How has your child's weight changed in the last 2-3 months: ❑ little or no change ❑ up __________lbs. ❑ down ______ lbs.

CURRENT STATUS OF CHILD

Please Check Any of the Following Problems which Pertain to Your Child and/or Your Family:

Present	Past		Present	Past	
❑	❑	Stress	❑	❑	Parenting problems
❑	❑	Anxiety or worry	❑	❑	Physical abuse
❑	❑	Panic	❑	❑	Emotional abuse
❑	❑	Depression	❑	❑	Verbal abuse
❑	❑	Crying all the time	❑	❑	Sexual abuse
❑	❑	Lack of motivation	❑	❑	Sexual problems
❑	❑	Fatigue/Lack of energy	❑	❑	Gender identity
❑	❑	Poor appetite or overeating	❑	❑	Anger
❑	❑	Trouble sleeping	❑	❑	Aggressive behavior
❑	❑	Poor concentration	❑	❑	Bad dreams
❑	❑	Feeling worthless or inferior	❑	❑	Unwanted memories
❑	❑	Feeling hopeless	❑	❑	Loss of control
❑	❑	Guilt	❑	❑	Impulsive behavior
❑	❑	Death of friend or loved one	❑	❑	Controlling
❑	❑	Grief	❑	❑	Controlled by others
❑	❑	Chronic pain	❑	❑	Obsessive thoughts
❑	❑	Physical disability	❑	❑	Compulsive behaviors
❑	❑	Terminal illness	❑	❑	Seeing things others don't see
❑	❑	Health concerns	❑	❑	Hearing voices
❑	❑	Loneliness	❑	❑	Racing thoughts
❑	❑	Fears	❑	❑	Eating problems
❑	❑	Shyness	❑	❑	Drug use
❑	❑	Low self-esteem	❑	❑	Alcohol use
❑	❑	Don't like myself	❑	❑	Pregnancy
❑	❑	Marital problems	❑	❑	Abortion
❑	❑	Other relational problems	❑	❑	Legal matters

- ❑ ❑ Work stress
- ❑ ❑ Career choices
- ❑ ❑ Indecisiveness
- ❑ ❑ Lack of discipline
- ❑ ❑ Financial problems
- ❑ ❑ Spiritual apathy
- ❑ ❑ Other ___________________

Is your child presently experiencing any suicidal thoughts? ☐ Yes ☐ No

Have they experienced them in the past? ☐ Yes ☐ No

Have they ever attempted suicide? ☐ Yes ☐ No

If Yes, when and how: ____

Have any of their friends or family ever committed or attempted suicide? ☐ Yes ☐ No

If Yes, when and who: ____

Is your child presently experiencing any thoughts of harming another person? ☐ Yes ☐ No

PEOPLE LIVING WITHIN HOME OF CHILD/ADOLESCENT

How many times has your family moved in the past year? ________________________________

Has an adult besides yourself moved into or out of your home in the last year? □ Yes □ No

If Yes, please explain: ____

Describe how well you get along with your spouse/significant other: ________________________

____

Does the child/adolescent's grandparents live in the home? □ Yes □ No

How many of the child/adolescent's siblings live in the home? ______________________________

Do any of the siblings provide support/advice to the child when he/she needs it? □ Yes □ No

Has a psychological or psychiatric evaluation ever been done on your child? □ Yes □ No

If yes, what were the results: ____

Has your family ever been investigated by Department of Children and Family Services? □ Y □ N

If Yes, Please Explain: ____

FAMILY ACTIVITIES

How often does your family have dinner together? _________Do activities together? __________

If you do activities with your family, what are they? ___________________________________

What time is your child's curfew on school nights?___________ Weekend Nights? ___________

Do you give your child specific chores around the house? □ No □ Yes (please specify)

____

If your child does not follow the rules or disobeys, what are the consequences for his/her behavior?____

____

____

CHILD'S SCHOOL INVOLVEMENT

Is your child in any advanced classes this year? □ No □ Yes _______________________________

What grades did your child get on his/her last report card? _______________________________

If your child is failing classes, how many classes and which ones?

This Year_____________________________ Last Year: ______________________________

Has your child had a discipline problem at school?

This Year_____________________________ Last Year: ______________________________

Does your child like school? □ Yes □ No

How regularly does your child attend school? □ Every day □ Most days □ Some days □ Never

Does your child/adolescent have friends? □ Yes, I have met most of them □ Yes, but I have never met them □ My child does not talk about his/friends □ No friends at all

Is your child involved in any extracurricular activities? □ Yes □ No □ I don't know

If Yes, what: ____

CRIMINAL INVOLVEMENT AND SUBSTANCE USE OF CHILD AND FAMILY

Has your child or any family members ever been arrested? □ No □ Yes (please explain)

____

Does your child use alcohol or drugs? □ Never □ Has experimented once or twice □ Uses every weekend □ Uses several times a week □ Uses Daily □ I don't know

Do the adults in your home use alcohol or drugs? □ Yes □ No □ I don't know

Do other children in the home use alcohol or drugs? □ Yes □ No □ I don't know

CURRENT ISSUES AND GOALS

Please describe why you are coming to counseling (i.e. What Are Child's Issues, Problems?):

____

____

How long have you had this problem?____

____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

|____|

Minimally Distressing	Moderately Distressing	Extremely Distressing

How Long Do You Believe Counseling Should Last:

____

What do you hope to gain or change by coming for counseling? ____________________________

____

____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care Your Child Has Received (Use Back If Necessary):

Therapist: ____________________________ Location: ____________________ Dates: _________

Reason: ____

Therapist: ____________________________ Location: ____________________ Dates: _________

Reason: ____

RELIGIOUS BACKGROUND

Do You Regularly Attend a Place of Worship: □ Yes □ No. If Yes, Where: _____________________

What Is the Name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader: ___________________

Do You Have a Personal Support System: □ Yes □ No. If Yes, Who: _________________________

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: ____ Date: ___________________

Statement of Counseling Policies and Procedures

COUNSELING SESSIONS
Counseling sessions are 50-60 minutes in length for individuals and 65-75 minutes in length for couples.

FEES
Initial Intake Assessment Session (i.e. your first session) for Individual Sessions cost $140 and for Couple Sessions cost $165. After your initial session, the fee is $125 for Individual Sessions and $150 for Couple Sessions. If you are undergoing a financial hardship, contact us to discuss options available for financial assistance. We do not want finances to keep you from getting the help you need.

PAYMENTS
Payment is due upon the completion of each session. You may pay by cash, check or credit card. Checks should be made payable to "Kalon Christian Counseling." Accounts must be kept current in order to continue counseling at Kalon Christian Counseling.

INSURANCE
We counsel on a fee-for-service basis and do not accept or file any insurance on your behalf. However, we can provide you with a medical receipt if you choose to pursue personal reimbursement from your insurance company. To do this, you must call your insurance company directly to see if you have out-of-network mental health coverage.

RESCHEDULING APPOINTMENTS
It is our policy to schedule you for a “standing appointment.” Concluding each session we will confirm your next scheduled appointment. Standing appointments will only be rescheduled if an alternative time is available.

CANCELLATIONS/ NO SHOWS
If you must cancel your appointment, please **call at least 24 hours in advance** of your scheduled time. All appointments that are not canceled and/or canceled less than 24 hours before the appointment time (except in case of an emergency out of your control) are subject to a late cancellation charge equal to the session fee.

CONTACT INFORMATION
It is understood that occasionally you may need to consult with your counselor briefly by telephone or email. In most cases your counselor will not be available immediately. However, every effort will be made to return your call or email within 24 hours. For brief consultations there is no charge. However, for all communication lasting longer than ten minutes, there is a $2.00 per minute fee.

EMERGENCY CONTACT INFORMATION
If you feel that you need immediate help and/or are experiencing a medical emergency contact your family physician or nearest emergency room and ask for the psychologist or psychiatrist on call. If you are experiencing a life-threatening emergency call 911 or go to the nearest hospital emergency room.

Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of *treatment, payment, and health care operations*.

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

- *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law.

You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that we restrict using and disclosing your Protected Health Information to family members and relatives, friends, or others you identify. We reserve the right to deny this request.

- You may request an amendment to your Protected Health Information.

- You may request alternative means or locations in which you receive confidential communications.

- You may request an accounting of disclosures of Protected Health Information beyond treatment, payment, and health care operations.

We are required by law to protect the privacy of your Protected Health Information and to abide by the terms of the Notice of Privacy Practices. We will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request.

You may file a formal, written complain with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information regarding our Privacy Practices, please contact:

- Kalon Christian Counseling
  120 North Crawford Street
  Thomasville, GA 31792
  (229) 234-7337

For more information about HIPAA or to file a complaint, please contact:

- The U.S. Department of Health & Human Services
  Office of Civil Rights
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  877 – 696 – 6775 (Toll free)

Acknowledgement of Receipt of Privacy Practices Notice

I, ____have received a copy of Kalon Christian Counseling's Notice of Privacy Practices.

Name: ____

Street Address: ____

City: ______________________________________ State: ____________ Zip Code: _______________

Signature of Client:____ Date: ___________________

Signature of Guardian:____ Date: ___________________
(If client is a minor)

Witnessed by:____ Date: ___________________

Signature of Witness: ____

Informed Consent and Release of Liability to Treat a Minor Client (Pages 1 of 2)

Counseling services offered by Kalon Christian Counseling is for the express purpose of providing emotional, psychological, relational and spiritual support with a distinctively Christian framework to the local church and to the community as a whole. I, Dusty Hart, am a Licensed Professional Counselor and practice as such under GA State Law (GA Code Title 43-10A-11). My training is a combination of Christian Soul Care, Theology, and Psychology. Both my graduate training and counseling approach reflect a unified, biblical perspective on the mental, emotional, spiritual, physical and relational parts of our personhood.

The completion of an **Intake Questionnaire** and an **Informed Consent and Release of Liability** form are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent. While I expect benefits for my child from treatment, I fully understand that such benefits and particular outcomes cannot be guaranteed. I understand that because of the treatment, my child may experience emotional strain, feel worse during treatment, and make life changes which could be distressing. I also understand regular attendance will produce the maximum benefits but that I am free to discontinue treatment for my child at any time. If I decide to do so I will notify the provider at least two weeks in advance so that effective discharge planning for my child can be implemented.

1. I ____ understand that Dusty Hart, my counselor, is a Licensed Professional Counselor (LPC) in the State of Georgia.

2. I understand that contents of all my child's therapy sessions are considered confidential. Both verbal information and written information about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

   • When a client discloses intentions or a plan to harm self or another person, the mental health professional is required to notify legal authorities and those people who may be impacted.

   • If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Informed Consent and Release of Liability to Treat a Minor Client (Pages 2 of 2)

- When a mental health professional is made aware of prenatal exposure to controlled substances that are potentially harmful, a report must be made to the appropriate authorities.

- Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

- Insurance companies (when applicable) and other third-party payers are given information that they request regarding services to clients, such as types of service, dates/times of service, diagnosis, treatment plan, progress of therapy, case notes, and summaries.

3. I waive any right I may otherwise have to seek to use my counseling records with Kalon Christian Counseling, except as may otherwise be agreed upon in writing, in any judicial proceeding or to compel the testimony of any Counselor or supervisor associated herewith. If testimony is required, I agree to pay twice the normal hourly rate for any, and all, of these individuals for their testimony, and preparation therefore.

In consideration of the benefits to be derived from counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable First Presbyterian Church of Thomasville, its officers, leadership and employees or the ministry of Kalon Christian Counseling, the Counselors, and supervisors, if applicable, from any and all claims, demands, actions or causes of actions of whatsoever kind and nature related to the counseling process.

I understand that once my child reaches the age of majority my consent for treatment is no longer required.

I have read and understood the preceding information and agree to the policies of Kalon Christian Counseling as stated herein. I understand that these comments are prerequisite to my receiving and continuing counseling through Kalon Christian Counseling.

Signed:____ Date: _______________________

Witness: ____ Date: _______________________

Minor Child Not Living With Both Legal and/or Biological Parents

Please complete this form only in cases where a minor child does not live with both legal and/or biological parents. Please be aware that Kalon Christian Counseling must contact the other parent via mail or telephone if both parties are not present during the initial intake session.

Contact Information

Mother's Name: ________________________________ Phone Number: __________________________

Father's Name: _________________________________ Phone Number: __________________________

Living and Medical Arrangements

What is the living arrangement of the minor client?

____

____

Primary Residence of the minor client: □ Mother □ Father

Street Address: ____ Suite/Apartment Number: _______

City: ______________________________________ State: _____________ Zip Code: ________________

Secondary Residence of the minor client: □ Mother □ Father

Street Address: ____ Suite/Apartment Number: _______

City: ______________________________________ State: _____________ Zip Code: ________________

What is the arrangement for seeking medical services on behalf of the minor client?

____

____

What document type has determined these arrangements (e.g. divorce decree, separation order, temporary order, etc.)? ____

____