KALON
CHRISTIAN COUNSELING

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? _____

_____

_____

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

❑	❑ 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: _____

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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.

KALON
CHRISTIAN COUNSELING

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
  3201 Shamrock St S # 103,
  Tallahassee, FL 32309
  (850) 778-1460

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)

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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: _____

KALON
CHRISTIAN COUNSELING

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 Mental Health Counselor and practice as such under FL State Law (Chapter 491, Florida Statues). My training is a combination of Psychology, Theology, and Christian Soul Care. 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 Mental Health Counselor (LMHC) in the State of Florida.

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.

• 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 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: _____

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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.)? _____

_____