TRINITY COUNSELING

CHILD/ADOLESCENT INTAKE FORM

Today's Date: _____

Client Information:

Client Name: _____ Date of Birth: _____

Age: _____ Gender: M F

Name of person completing this form: _____

Relationship to client: _____

Residence of child: (circle) Biological parents Adoptive parents Foster Parents

Other (please explain) _____

Client Contacts:

Mother's name: _____ Age: _____

Mother's Address: _____

Mother's Email:_____

Mother's Contact Number(s)_____

Home Work Cell

Father's name: _____ Age: _____

Father's Address: _____

Father's Email:_____

Father's Contact Number(s)_____

Home Work Cell

Preferred Method of Contact: _____

Marital Status of Parents: (circle) Married Divorced Separated Widowed

Who has physical/legal custody?: _____ Type: _____

Parenting Plan or Custody Orders: _____ Yes _____ No

Will you be willing to provide a copy: _____ Yes _____ No

Support Services:

Does this individual receive services from Health and Welfare? ____ Yes _____ No

Case worker:_____ Phone: _____

Services Received: _____

Referral Information:

Who referred you to Trinity Counseling? _____

Presenting Issues:

_____

_____

_____

What concerns you most about this individual?

_____

_____

_____

When did you first notice this issue:

_____

_____

_____

How has this issue affected his/her function?

At home: _____

_____

_____

At school/work: _____

_____

_____

Community: _____

_____

_____

Any other concern you want to address? _____

_____

What are your goals/expectations for treatment? _____

_____

Have you recently worried that your child has (please circle items relevant to your child):

____ DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/ isolating behaviors, lack of interest in things. etc.)

_____ ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.)

_____ BEHAVIORAL PROBLEM (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)

_____ ATTENTION/HYPERACTIVITY PROBLEMS (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)

_____ ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)

____ SOCIAL ANXIETY (shy and/or afraid to be around others)

____ REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.)

____ AUTISM (social and language impairments, rigidity)

____PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)

____DISSOCIATION (feeling outside your body or things are not real, etc.)

Has your child ever harmed themselves intentionally? Attempted suicide? Harmed others? _____

_____

Sleep Patterns:

Total hours of sleep per night:_____ Usual Schedule: _____ to_____.
Does the individual take naps during the day? ____yes _____No
If Yes, how many hours in a typical day? _____

Concerns:	Current Issues	Change within last 6 months
Difficult falling asleep:	Yes No	Yes No
Frequent awaking:	Yes No	Yes No
Snoring:	Yes No	Yes No
Restlessness/Movements	Yes No	Yes No
Early Morning awaking:	Yes No	Yes No
Nightmares:	Yes No	Yes No
Not rested:	Yes No	Yes No

If yes to any of the concerns above, please describe:

_____
_____
_____

Past Psychiatric History:

Please list any previous psychiatric hospitalizations, residential or day treatment programs (including any alcohol or drug treatment programs).

Diagnosis_____Length_of_Stay_____Treatment_____Response

_____
_____
_____

List any current or prior outpatient psychiatrist and therapist your child has seen?

Name Title Location how long

_____
_____
_____

Allergies (drug, food. seasonal, environmental, ect) ___ Yes ____ No If yes, please name and describe:

_____
_____
_____

Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, the following policy has been prepared. This is because the use of various types of electronic communications is common in our society, and many individuals prefer this method of communication. This does put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy as been prepared to assure the security and confidentially of your treatment and to assure that it is consistent with our ethics and the law.

If you have questions regarding this policy, please feel free to discuss this with me.

_____ **Email Communications**

My office staff may use email communication and text messaging only with your permission and only for administrative purposes unless we have made other agreements. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues.

Email is not a secure form of communication so I will not respond in any detail to emails regarding clinical matters, such as treatment questions. If you need to discuss a clinical matter with me, please feel free to call me and we can discuss it on the phone or wait until we have our next session.

_____ **Text Messages**

Communication by text messages is insecure. Please use text messaging for issues such as, changing or confirming appointments. Any other messages I will respond by asking you to call me.

_____ **Minors**

If you are under the age of eighteen, please be aware that the law may provide your parents or legal guardian(s) the right to examine your treatment records. It is my policy to request an agreement from parents or legal guardian(s) that I provide then only with general information about our work together, unless I feel there is a high risk you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will provide them with a summary of your treatment upon their request. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

_____ **Divorce**

If you have been or are not going through a divorce, please understand that, legally, I am not a part of the divorce and am not bound to any divorce decree issued by a court of law. The person who presents him/herself or a minor for treatment is responsible for paying the treatment bill. If your divorce decree that an ex-spouse is to pay any portion

of the treatment bills, you must pay me at the time of service and then seek payment from your ex-spouse per terms of your divorce decree.

All parents or legal guardian(s) need to consent for treatment with a minor child. I will need the names, address and phone numbers for these adults. I will also need all parents or legal guardian(s) to all relevant paperwork. If a parent states he/she has sole custody/ guardianship of a minor child, that parent will need to bring that paperwork from the court that verifies this. I encourage all parents or guardian(s) to be present for the initial session for minor children. Attendance and/or parent/guardian participation in follow up sessions with vary depending on the treatment plan.

_____ **Consent for Treatment**

You voluntarily consent to receive services which any include any or all of the following: individual, group or family therapy; crisis intervention; and referral recommendations deemed necessary and advisable in the judgment of Nicole Rojas, p-LPC. If the client is a minor child or otherwise incapable of providing consent to the same services for him/ her. You have the right to accept, refuse or stop treatment at any time.