Child / Adolescent Counseling Intake Form

237 Taconic Road, Greenwich, CT 06831
FAX: 203 340 9815

PARENT/GUARDIAN INFORMATION

Name: ______________________ Date: ______________

Street Address: ______________________ Phone (h) ______________

City, State, Zip: ______________________ Phone (w) ______________

E-mail Address: ______________________ Phone (cell) ______________

For confidentiality, when and where do you prefer to be reached? ______________

Marital status: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Date of Current Marriage/Separation: ______________ Number of Marriages: ______________

Child(ren)'s Names: ______________ Date of Birth: ______________ ○ M ○ F

______________ Date of Birth: ______________ ○ M ○ F

______________ Date of Birth: ______________ ○ M ○ F

Occupation: ______________________

Name of other custodial parent: ______________________ Phone ______________

Do you have consent from the other custodial parent for treatment of said child? ○ Yes ○ No
If no, this will be required by the therapist before counseling may begin.

How much contact does the child have with his/her biological mother/father? ______________

Do you believe in God? ○ Yes ○ No Religious preference: ______________

What church do you currently attend? ______________

How much influence does your religion have on your day-to-day activity? ______________

Please specific days/times for your appointment availability:

Monday: ○ morning ○ afternoon ○ evening
Tuesday: ○ morning ○ afternoon ○ evening
Wednesday: ○ morning ○ afternoon ○ evening
Thursday: ○ morning ○ afternoon ○ evening
Friday: ○ morning ○ afternoon ○ evening

GENERAL INFORMATION (Complete all remaining information according to the child coming for treatment.)

Name: ______________________ Date of Birth: ______________ ○ M ○ F

The child is currently living with: ______________________

School: ______________________ Grade: ______________

Extracurricular activities/interests: ______________________

237 Taconic Road, Greenwich, CT 06831
FAX: 203 340 9815

MEDICAL INFORMATION

How would you rate your child's current physical health? ○ Excellent ○ Good ○ Fair ○ Poor

Is the child complaining of any physical problems? (headaches, stomach aches…) ______________________

____

Previous hospitalizations for medical reasons: Date ____________ Reason ______________________

Date ____________ Reason ______________________

Please list any medical conditions or disabilities: ______________________

Medication(s) Over-the-counter or prescription	**Dosage**

Please list any learning disabilities: ______________________

COUNSELING & PSYCHIATRIC HISTORY

Has the child had any previous counseling? ○ Yes ○ No If yes, for how long? ____________

For what reason? ______________________ Name/location of counselor: ____________

Has the child ever been diagnosed with or treated for any type of mental illness? ○ Yes ○ No

If yes, which type? ______________________

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness? ○ Yes ○ No

If yes, which type? ______________________

Psychiatric Medication(s)	**Dosage**

Reasons For Seeking Help

What concerns about the child have led you to pursue counseling? ______________________

____

____

237 Taconic Road, Greenwich, CT 06831

FAX: 203 340 9815

Where are these concerns causing the most problems? Check all that apply:

○ Home ○ Work ○ School ○ Other: ______________________________

When did the present concerns begin to be a problem for the child? ______________________________

What concerns about the child have been identified by others? ______________________________

Please indicate which of the following areas are currently problems for the child. Check all that apply:

- ○ Lack of motivation
- ○ Excessive fears or anxieties
- ○ Difficulty being away from specific family members
- ○ Loss of interest in usual activities
- ○ Hearing Voices
- ○ Nightmares
- ○ Difficulty falling asleep/inability to sleep at night
- ○ Decreased/increased appetite
- ○ Hyperactivity
- ○ Temper Tantrums
- ○ Bullying/picking fights
- ○ Refusal to respond to authority
- ○ Getting into trouble at school/play
- ○ Obsessions/compulsion with specific activities
- ○ Crying spells
- ○ Lack of self-confidence
- ○ Difficulty making or keeping friends
- ○ Other: ______________________________

How did you hear about our Counseling Services? ○ Friend ○ Pastor ○ Church ○ Other: ____________

What do you hope to gain from counseling? ______________________________

____

CONSENT FOR COUNSELING OF MINORS (age 17 and under)

This is to certify that I give permission for the minor named above to participate in counseling.

Printed Name of Parent/Guardian ______________________________

Signature of Parent/Guardian ______________________________ Date ____________

Emergency Contact Name ______________________________ **Relationship to child** ____________

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________

237 Taconic Road, Greenwich, CT 06831
FAX: 203 340 9815

COUNSELING AGREEMENT

In the interest of full disclosure about the counseling you will be receiving, please read through this following agreement, sign and date it at the bottom. This form must be signed and included with the intake form in order to begin counseling.

Description of Counseling

Based on your counseling needs, you may be advised to take appropriate tests/inventories or seek medical treatment to facilitate the counseling process. Each of our counselors adheres to the code of ethics prescribed by his/her respective professional body.

Referral Policy/Disclaimer

Clients will be referred outside when treatment required is beyond the scope of care available here. Though we strive to be responsible and professional in the referral procedure, it is your full right and responsibility to select the professional of your choice. We are not liable for any services provided or not provided by the referred professional.

Counseling Fees

Each therapist's fees are listed by their professional information on our website. Fees are for 50-minute sessions and payment is due at the beginning or the end of each session. Accounts must be kept current in order to continue counseling. Cash or checks are accepted forms of payment.

Please note that we are unable to accept insurance. However, we provide clients with receipts for reimbursement of out-of-network insurance benefits. Because insurance plans vary, please first check with your insurance provider to see if you have out-of-network benefits and whether you will qualify for reimbursement.

Confidentiality

To release information without your consent would violate commonly accepted codes of counseling ethics. There are situations, however, in which we are required by law to reveal information without your consent. Please see the **"Notice of Policies and Practices to Protect the Privacy of Your Health Information"** given to you at your initial session for details. All counselors participate in regular peer supervision. During this supervision your personal identity will be concealed. The purpose of supervision is to ensure quality of care.

Rights As a Client

1. You are entitled to information about any procedures, methods of counseling, techniques, and possible duration of counseling.
2. You have the right to end counseling at any time without any moral, legal, or financial obligations other than those already accrued.
3. You have the right to expect confidentiality within the limits described in the Notice of Policies and Practices to Protect the Privacy of Your Health Information.
4. You have the right to request in writing the release of your records to any person or agency.
5. You have the right to authorize your counselor to consult with another professional about your counseling in writing.
6. You have the right to file a grievance in writing with the Director if you have concerns that your rights as a client have been violated.

Mediation & Arbitration

All disputes arising out of or in relation to this agreement to provide services shall first be referred to mediation, before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the counselor and client. The cost of such mediation, if any, shall be shared equally.

Cancellation Policy

We request that you notify your Counselor at least **24 hours** before your scheduled appointment time if you need to cancel a session. *Failure to do so will result in charges for the missed appointment.* This charge should be paid before or at the time of your next appointment to continue in the counseling relationship. Exceptions are for emergencies only.

Contacting Your Counselor

For scheduling and canceling your appointments, you must contact your counselor directly. For general information, please contact the reception desk during regular offices hours of 9:00 AM - 5:00 PM. For emergencies after-hours, please contact 911 or your local emergency room.

If these guidelines are acceptable to you, please sign below:

Signed ______________________________ Date ______________

Witness ______________________________ Date ______________

(Required if under the age of 18)