McDermott Counseling, LLC

Child and Adolescent Intake

Client's name: _____ Date of birth: ____ /____ /____

Gender: ☐ F ☐ M Age: _____ School:_____ Grade in school: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Cell Phone (If child has their own): (_____)_____-_____

Insurance Company Name:_____ ID # :_____ Group # : _____

Answer the following regarding PRIMARY INSURED: Name:_____ DOB: ____/____/____

Address: _____

SSN: _____-____-_____ Telephone # (_____) _____-_____ Employer: _____

Person to contact in case of Emergency:_____

Relationship: _____ Phone: home # (_____) _____-_____ cell # (_____) _____-_____

Primary reason(s) for seeking services: _____

_____

Family Information

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Is there any significant information about the parents' relationship ? ☐ Yes ☐ No If Yes, describe _____

_____

_____

Client's Mother

Name: _____ Cell Phone: (_____) _____-_____ Age: _____Mother's education:_____

Occupation: _____Employer:_____

Is there anything notable, unusual or stressful about the child's relationship with the mother? ☐ Yes ☐ No If Yes, please explain:

_____

_____

Client's Father

Name: _____ Cell Phone: (_____) _____-_____ Age: _____Father's education:_____

Occupation: _____Employer:_____

Is there anything notable, unusual or stressful about the child's relationship with the father? ☐ Yes ☐ No If Yes, please explain:

_____

_____

Client's Siblings and Others Who Live in the Household

Names of Sibling	Age	Gender	Lives at:	Quality of the relationship with the child
_____	____	☐F ☐M	☐home ☐away _____	☐poor ☐average ☐good
_____	____	☐F ☐M	☐home ☐away _____	☐poor ☐average ☐good
_____	____	☐F ☐M	☐home ☐away _____	☐poor ☐average ☐good
_____	____	☐F ☐M	☐home ☐away _____	☐poor ☐average ☐good

Others living in the household (i.e. step-parent, grandparent,)	Age	Gender	Relationship to the child	Quality of the relationship with the child
_____	____	☐F ☐M	_____	☐poor ☐average ☐good
_____	____	☐F ☐M	_____	☐poor ☐average ☐good
_____	____	☐F ☐M	_____	☐poor ☐average ☐good
_____	____	☐F ☐M	_____	☐poor ☐average ☐good

Pregnancy & Birth

Was the pregnancy with your child planned? ☐ Yes ☐ No Mother's age at child's birth: ___ Father's age at child's birth: ___

Length of pregnancy: _____ While pregnant did the mother use tobacco, drugs, or alcohol? ☐ Yes ☐ No

If Yes, describe : _____

While pregnant, did the mother have any medical or emotional difficulties: ☐ Yes ☐ No If Yes, describe: _____

_____

Length of labor: _____ Induced: ☐Yes ☐No Caesarean? ☐ Yes ☐ No Birth weight: _____

Where there any physical or emotional complications with the delivery? ☐ Yes ☐ No If Yes, describe _____

_____

Where there any complications for the mother or the baby after the birth ☐ Yes ☐ No If Yes, describe: _____

_____

Infancy/Toddlerhood (Check all which apply)

☐ Breast fed	☐ Milk allergies	☐ Vomiting	☐ Diarrhea	☐ Resisted solid food
☐ Lethargic	☐ Rashes	☐ Colic	☐ Constipation	☐ Irritable when awakened
☐ Not cuddly	☐ Cried often	☐ Rarely cried	☐ Overactive	☐ Trouble sleeping

Developmental History (Please note the age at which the following behaviors took place)

Sat alone: _____ Fed self: _____ Weaned: _____ Took 1st steps: _____ Spoke words: _____

Spoke sentences: _____ Toilet trained: _____ Dry during day: _____ Dry during night: _____ Dressed self: _____

Tied shoelaces: _____ Rode two-wheeled bike: _____ Overall your child's development was: ☐ slow ☐ average ☐ fast

Education

Current school:_____ Grade: _____ School phone number: _____

In special education? ☐ Yes ☐ No If Yes, describe: _____

Has child ever been held back in school? ☐ Yes ☐ No If Yes, explain: _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? ☐ Yes ☐ No If Yes, describe:_____

Has the child been tested psychologically? ☐ Yes ☐ No If Yes, describe:_____

Check the descriptions which ***you feel***, specifically relate to your child:

Feelings about School Work:

☐ Anxious ☐ Passive ☐ Enthusiastic ☐ Fearful ☐ Rebellious

☐ Eager ☐ No expression ☐ Bored ☐ Other (describe): _____

Approach to School Work:

☐ Organized ☐ Industrious ☐ Responsible ☐ Interested ☐ Doesn't complete assignments

☐ Self-directed ☐ No initiative ☐ Refuses ☐ Disorganized ☐ Does only what is expected

☐ Sloppy ☐ Cooperative ☐ Other (describe): _____

Performance in School:

☐ Satisfactory ☐ Underachiever ☐ Overachiever ☐ Other (describe): _____

Child's Peer Relationships:

☐ Spontaneous ☐ Follower ☐ Leader ☐ Makes friends easily ☐ Difficulty making friends

☐ Shares easily ☐ Long-time friends ☐ Other (describe): _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ☐ Yes ☐ No If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious **(parents answer - regarding you and your family)**

How important to you are spiritual matters? ☐ Not at all ☐ Little ☐ Moderate ☐ Very Much ☐ Not Currently Practicing

Are you affiliated with a spiritual or religious group? ☐ Yes ☐ No Name and Type:_____

Leisure/Recreational

Describe special areas of interest, sports, or hobbies your child enjoys. (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

List any current health concerns: _____

_____

List any previous health concerns since birth: _____

_____

Current prescribed medications	Dose	Dates	Prescribing M.D.	Purpose
		____ to ____		
		____ to ____		
		____ to ____		

Current over-the-counter meds	Dose	Dates	How Often	Purpose
		____ to ____		
		____ to ____		
		____ to ____		

Chemical Use History

Has your child (to your knowledge) ever used alcohol or drugs? ☐ Yes ☐ No If yes, describe: _____

_____

Counseling/Prior Treatment History

Has child ever received counseling, therapy, or psychiatry in the past? ☐ Yes ☐ No. If yes: Name & telephone of Provider:

_____

Treatment dates: _____ Reason for treatment: _____

List Concerns and Significant Changes in your child's life: _____

_____

_____

Please write a 1 in front of the problems listed below which are of *primary* concern to you

Please write a 2 in front of the problems listed below which are of *secondary* concern to you

___ Affectionate	____ Frustrated easily	____ Sad
___ Aggressive	____ Hallucinations	____ Selfish
___ Alcohol problems	____ Head banging	____ Separation anxiety
___ Anger	____ Heart problems	____ Sets fires
___ Anxiety/ excessive worry	_____ Helplessness	____ Sexual addiction
___ Attachment to dolls	____ Hurts animals	____ Sexual acting out
___ Avoids adults	____ Imaginary friends	____ Shares
___ Bedwetting	____ Impulsive	____ Sick often
___ Blinking, jerking	____ Irritable	____ Short attention span
___ Bizarre behavior	____ Lazy	____ Shy, timid
___ Bullies, threatens	____ Learning problems	____ Sleeping problems
___ Careless, reckless	____ Lies frequently	____ Slow moving
___ Chest pains	____ Loner	____ Soiling
___ Clumsy	____ Low self-esteem	____ Speech problems
__ Defiant	____ Moody	____ Stomach aches
___ Depression	____ Nightmares	____ Steals
___ Destructive	____ Over active	____ Suicidal threats
___ Difficulty speaking	____ Obsessive	____ Suicidal attempts
___ Eating disorder	____ Often sick	____ Talks back
___ Excessive masturbation	____ Oppositional	____ Tics or twitching
___ Fatigue	____ Overweight	____ Teeth grinding
___ Fearful	____ Panic attacks	____ Thumb sucking
___ Frequent injuries	____Poor appetite	____ Weight loss
___ Expects failure	____ Phobias	____ Withdrawn

Please describe any of the above concerns: _____

_____

_____

_____

What are ***your*** goals for the child's therapy? _____

_____

_____

_____

McDermott Counseling, LLC
Consent for Treatment and Patient Agreement

Welcome to McDermott Counseling, LLC. Your therapy is an important joint venture in which you (your child & family) and I will work together to understand the problems that you are having and to explore your options and obstacles in resolving those problems. This document contains information about our professional services and business policies. Should you have any questions about these at any time, we will be happy to answer them.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on many factors, including the personalities of the patient and therapist, your early experiences, your life stage, and your goals. There are several different approaches that can be used. Psychotherapy requires an active effort on your part and a working relationship with me in which together we identify the issues you and your child would like to resolve.

Psychotherapy can have both benefits and risks. Since therapy often involves discussing difficult aspects your child's life, your child may experience uncomfortable feelings and you may initially notice undesirable changes in your child's behaviors. This is a normal part of the therapeutic process. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful. It often leads to a significant reduction of feelings of distress, improved relationships, and resolutions of specific behavioral problems.

Our first sessions will involve an evaluation of you and your child's needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan/goals if you decide to continue.

You have the right to stop treatment at any time. The process of termination is generally one of the most important times in therapy. We therefore require two to four sessions to work through this process of termination. I also ask that I work with parents to set a termination date before it is discussed with the child. Termination is a delicate process with children, and must be handled appropriately by all of us.

CONFIDENTIALITY

With certain specific exceptions described below, you and your child have the absolute right to the confidentiality of your child's therapy. We cannot and will not tell anyone else what you or your child has told us, or even that your child is in therapy with us, without your prior written consent. The following are legal exceptions to your right to confidentiality. Should one of these situations occur, we will make every effort to discuss it with you fully before taking any action.

- If we reasonably suspect that a person under 18 or over 65, or a disabled person, is being abused or has been abused, we must file a report with the appropriate state agency
- If a patient threatens to harm him/herself, we may be obligated to seek hospitalization for the patient, or to contact family members or others who can help provide protection.
- If a patient communicates a serious threat of physical violence against an identifiable victim, we must take protective actions, including notifying the potential victim and contacting the police. we may also seek hospitalization of the patient, or contact others who can assist in protecting the victim.
- We may find it helpful to consult with professional colleagues about our work from time to time. In these consultations, we make every effort to avoid revealing the identity of the patient. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.
- If you are involved in a court proceeding and a request is made for information about the services that we have provided you and your child and/or the records of them, such information is protected by therapist-patient privilege law. When working with minors, the therapist (not the parent) is holder of the privilege. We therefore cannot provide any information without, a court order, compulsory process (a subpoena) or discovery request from another party to the court proceeding where we do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult

with your attorney to determine whether a court would be likely to order us to disclose information about you or your child.

APPOINTMENTS

Psychotherapy appointments are usually scheduled once a week for **45 minutes per session**. We agree to meet here and to be on time. Sessions are scheduled on the hour and end 15 minutes before the next hour. If we are ever unable to start on time, we ask for your understanding, and assure you that you will receive the full time agreed to. If you are late, we will probably be unable to meet for the full time as the session will still end 15 minutes before the hour. Be assured the 15 minutes in between each session is spent working on your child's treatment by; writing progress notes, reviewing the last session's progress note (before you arrive) treatment planning, and various other tasks.

CANCELLATION POLICY

24 hours notice is required for rescheduling or canceling appointments. Insurance companies typically do not pay for missed appointments; therefore, you are responsible for the full session fee of $100 should you fail to provide24 hours notice. *(please note this is not only your co-pay, but the full session fee of $100.)*

PROFESSIONAL FEES

Our fee per 45 minute psychotherapy session is $100. The fee for a 60 minute session is $133. Bills are to be paid at the time of each visit. We accept cash only. We are unable to accept credit or debit cards at this time. We also charge this amount for other professional services you may need. Other services might include telephone conversations lasting greater than 5 minutes, attending meetings (i.e. IEP or 504 plans), consulting with other professionals at ***YOUR*** request, preparation of records, or any other service you may request of us. When fees are not paid for services rendered, a collection agency may be utilized and given appropriate billing and financial information.

If you become involved in legal proceedings that require our participation, you will be charged for all time involved, including preparation and travel (even if we are called to testify by another party). Because of the difficulty of legal involvement, we charge $300 per hour (for each therapist) for preparation, travel to and from, and attendance at any legal proceeding. We do **NOT** provide any reports requested by the patient, parent or guardian. Court reports are provided directly to the Judge in a SEALED & CONFIDENTIAL envelope, **by court order only**. *A subpoenas is NOT a court order; therefore, is NOT sufficient*. Health records are protected by HIPPA therefore require our physical presence at a court hearing to assert the patient/psychotherapist privilege prior to any information being released to the court or any other persons.

CONTACTING US

We are often not immediately available by telephone. When we are unavailable, our telephones are answered by confidential voicemail. We will make every effort to return your call on the same day you make it, with the exception of calls on weekends and holidays. Also, we do not return telephone calls between 7:00 p.m. and 8:00 a.m. If you are unable to reach us and feel that you cannot wait for a returned phone call, you may the Mental Health Crisis Hot Line at (800)321-1616, National Crisis Hotline (800)784-2433, Tulare County Crisis Line (559) 733-6877, or the emergency/police dispatcher at 911. If we are unavailable for an extended time, we will provide you with the name of a colleague whom you can contact if necessary.

Please sign below to acknowledge your informed consent to this agreement.

I have read the above information and have had an opportunity to ask questions which clarify the conditions under which I consent to the treatment of my child. I give permission to McDermott Counseling, LLC to provide an evaluation and psychotherapy to my child. I am aware that Rachel Sievers-Herrera M.S., Tracy Slack, M.S. , and Amy Durst, M.S., are Marriage and Family Therapy Interns, working towards their licensure. They have completed their education and conducting 3,000 hours of psychotherapy supervised directly by Rachel McDermott, LMFT prior to apply for their own license. I am also aware that *my child* is the patient of McDermott Counseling, LLC, I myself am not considered the patient although I participate in the treatment of my child.

_____ _____

Signature of patient Date

_____ _____

Signature of mother or guardian Signature of father or guardian