



# Counseling Institute of Atlanta, Inc.

Bilingual & Multicultural Mental Health Services

5855 Jimmy Carter Blvd., Suite 240, Norcross, GA, 30071

Office: (404) 630-1361 / Fax: (770) 441-9177

## ADOLESCENTS INTAKE FORM (13-17 years-old)

### I- DEMOGRAPHIC INFORMATION

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Where was your child born? \_\_\_\_\_

Residential Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phones: Home \_\_\_\_\_ Cell #: \_\_\_\_\_ Can we leave a message? Yes [ ] No [ ]

Parents (or legal guardian's information):

Father: \_\_\_\_\_ Age \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Mother: \_\_\_\_\_ Age \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

If parents are separated, how long have you been separated or divorced? \_\_\_\_\_

How long have you been living in Georgia? \_\_\_\_\_ How long in the United States? \_\_\_\_\_

Has lived in other states? Yes [ ] No [ ] Which? \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_

Reporting Person: \_\_\_\_\_ Relationship to Patient : [ ] Mother [ ] Father [ ] Other: \_\_\_\_\_

Contact person in case of emergency:

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

We will only contact this person if we believe it is a life or death emergency. Please indicate that we may do so: Yes [ ] No [ ]

Who does your child live with? [ ] father [ ] mother [ ] Both parents  
[ ] A family member (who) \_\_\_\_\_ Other person (who) \_\_\_\_\_

Who has the child's legal custody?

[ ] Both parents [ ] Mother [ ] Father [ ] DFCS [ ] Other \_\_\_\_\_



**IV- CURRENT SYMPTOMS OR BEHAVIORS CHECKLIST**

Mark only those that apply to your child or yourself if you are the teenager.

<input type="checkbox"/> ]Insomnia <input type="checkbox"/> ]Loneliness <input type="checkbox"/> ]Isolation <input type="checkbox"/> ]Sadness <input type="checkbox"/> ]Lack of energy <input type="checkbox"/> ]Loss of appetite <input type="checkbox"/> ]Crying for no reason <input type="checkbox"/> ]Low self-esteem <input type="checkbox"/> ]Anxiety <input type="checkbox"/> ]Nervousness <input type="checkbox"/> ]Panic attacks <input type="checkbox"/> ]Fears <input type="checkbox"/> ]Perfectionism <input type="checkbox"/> ]Shyness <input type="checkbox"/> ]Worrying too much <input type="checkbox"/> ]Feelings of guilt <input type="checkbox"/> ]Get distracted <input type="checkbox"/> ]Hyperactivity <input type="checkbox"/> ]Concentration problems <input type="checkbox"/> ]Impulsivity <input type="checkbox"/> ]Sudden temper changes <input type="checkbox"/> ]Anger <input type="checkbox"/> ]Loss of control <input type="checkbox"/> ]Aggressive <input type="checkbox"/> ]Violent	<input type="checkbox"/> ]Cruelty to animals <input type="checkbox"/> ]Problems with authority figures <input type="checkbox"/> ]Run away <input type="checkbox"/> ]Live in a bad neighborhood <input type="checkbox"/> ]Dizziness <input type="checkbox"/> ]Headaches <input type="checkbox"/> ]Shaking <input type="checkbox"/> ]Memory loss <input type="checkbox"/> ]Memory problems <input type="checkbox"/> ]Fatigue <input type="checkbox"/> ]Tired <input type="checkbox"/> ]Eating disorders <input type="checkbox"/> ]Sexually transmitted disease <input type="checkbox"/> ]Feel overweight <input type="checkbox"/> ]Too skinny <input type="checkbox"/> ]Purging alter eating too much. <input type="checkbox"/> ]Terminal illness <input type="checkbox"/> ]Unable to relax <input type="checkbox"/> ]Compulsive behaviors <input type="checkbox"/> ]Obsessive thoughts <input type="checkbox"/> ]Auditory hallucinations <input type="checkbox"/> ]Ideas of self-harm <input type="checkbox"/> ]Use of alcohol <input type="checkbox"/> ]Use of drugs <input type="checkbox"/> ]Smoke cigarettes	<input type="checkbox"/> ]HIV + <input type="checkbox"/> ]High expectations from parents <input type="checkbox"/> ]Don't have money <input type="checkbox"/> ]Sexual problems <input type="checkbox"/> ]Loosing my friends <input type="checkbox"/> ]Worried about becoming pregnant <input type="checkbox"/> ]I am pregnant <input type="checkbox"/> ]Don't know anything about sex <input type="checkbox"/> ]Peer pressure to have sex <input type="checkbox"/> ]Poor grades <input type="checkbox"/> ]Problems with my teachers <input type="checkbox"/> ]No Friends at school <input type="checkbox"/> ]I do not understand my school subjects <input type="checkbox"/> ]Hanging out with gangs <input type="checkbox"/> ]Pressure to join a gang <input type="checkbox"/> ]Fighting at school <input type="checkbox"/> ]Problems with parents <input type="checkbox"/> ]Parents are too strict <input type="checkbox"/> ]My parents have problems <input type="checkbox"/> ]Parents getting divorced <input type="checkbox"/> ]Sexual abuse at home <input type="checkbox"/> ]Physical abuse at home <input type="checkbox"/> ]Other (specify)
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**V- EDUCATIONAL HISTORY**

Name of current school \_\_\_\_\_ Grade \_\_\_\_\_

Has your child ever repeated a grade?  ] Yes  ] No Which Grade?: \_\_\_\_\_

Has your child been in special education?  ] Yes  ] No

Failing or low grades in the following subjects? \_\_\_\_\_

Behavioral Problems at School. Has he/she been expelled or suspended from school? \_\_\_\_\_

**VI- MEDICAL HISTORY**

Medical problems and medication your child takes \_\_\_\_\_

Has your child been hospitalized for medical problems?  Yes  No Explain the Reasons \_\_\_\_\_

**Mental Health**

Has your child ever received mental health treatment?  Yes  No

Please list any previous therapy/counseling received. \_\_\_\_\_

Has your child tried committing suicide or engage in self-harm?  Yes  No

When was the last time? \_\_\_\_\_ What method did your child use? \_\_\_\_\_

Did your child think about hurting another person? \_\_\_\_\_

Has your child been abused physically or sexually?  Yes  No

If your response is YES, please respond the following questions

Who is abusing him / her? \_\_\_\_\_ When did it happen? \_\_\_\_\_

Did anybody report it to DFCS or the Police?  Yes  No Who did it? \_\_\_\_\_

It has been miltreated with physical or psychological violence?  Yes  No

If your response is YES, please respond the following questions

Who is miltreated him / her? \_\_\_\_\_ When did it happen? \_\_\_\_\_

Did anybody report it to DFCS or the Police?  Yes  No Who did it? \_\_\_\_\_

**VII- SUBSTANCE USE HISTORY**

My child does not use drugs. Please continue with next section

My child use alcohol or drugs.

If the answer is affirmative, please respond to the following questions related to alcohol or drugs abuse.

Minor's substance use history

**VIII- CURRENT & PAST LEGAL HISTORY**

Has your child had any legal problem or ever been arrested?  Yes  No

If your response is affirmative, please explain. If your response is NO, please go to the next Section.





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## **INFORMED CONSENT FOR COUNSELING SERVICES WITH ADOLESCENTS**

Welcome to the Counseling Institute of Atlanta, Inc, for Counseling Services. Thank you for trusting us to assist you and your child with your concerns. It is our desire to help you in this moment of your life. We are honored that you have chosen us as your therapist. We will do everything we can to help you move forward and solve your problems.

Please take the time to complete this form, make sure you read and understand this document. If you have any questions, do not hesitate to ask your therapist.

**LIMITATIONS OF SERVICES:** I understand that the Counseling Institute of Atlanta, Inc.'s services are limited to counseling services including assessment, consultation, therapy, and intervention. I understand that assessment services may include the use of questionnaires or tests and intervention services may include counseling and psychotherapy. I understand that my therapist is not warranting a cure or offering any guarantee of results or improvement of any condition

**ASSUMPTION OF RISKS:** Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. Your active participation and commitment are important during this process. Some people may need a few sessions and others may need more. Come to our office on time according to your scheduled appointment. If for any reason, you are not able to attend, please let us know in advance so we can use that time with another client.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

I understand that the potential benefits of undergoing counseling services may include obtaining professional opinion and an increased understanding of myself. I understand that potential risks may include limited predictive validity of mental health assessment procedures, possible disagreement with the opinions offered to me, and possible emotional distress concerning my situation.

**LIMITS OF CONFIDENTIALITY:** I understand that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information or under certain other conditions listed below. I understand that confidential and privileged information may be released without my consent or authorization for the following purposes: (1) to provide needed professional services to the patient or the individual or organizational client, (2) to obtain appropriate professional consultations, (3) to protect the patient or client or others from harm (4) to obtain payment for services, in which instance the disclosure is limited to the minimum that is necessary to achieve the purpose. I hold the provider harmless for releasing information under any of the above conditions.

To release information about your therapy, I need to have written releases from you and your parents or legal guardian. In general, the law protects the confidentiality of all communications between clients and counselor. I only release information about our work with your written releases. Clients often give me releases to talk to their individual therapists, and/or previous therapists. This helps me to coordinate your therapy so that it will be most helpful to you.

There are also a few situations in which I am legally required to protect someone, even if that involves revealing some information about a client's treatment. 1. If I believe that a child, an elderly person or a disabled person is being abused, I may be required by law to file a report with the appropriate state agency. 2. If I believe that a client of mine is threatening serious bodily harm to another person, I may be required to take protective action, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. 3. If a client of mine threatens to harm him/herself, I may be required to seek hospitalization for that client, or contact family members or others who can help provide protection.

Occasionally, I find it helpful to consult with other professionals about a situation in therapy. In these consultations, I avoid revealing the identity of my clients. I will usually inform you of these consultations.

**TERMINATION OF THERAPY:** Each stage of therapy has important ramifications for the client's motivation, growth and self-esteem. Termination, although an ending of therapy, is a part of the development of the therapeutic relationship. A client who misses more than two sessions without notifying the therapist should be seen as initiating a premature termination. The staff from the Counseling Institute of Atlanta, Inc., will try to contact you, but your case will be terminated/closed if we do not hear back from you. If you are feeling better or planning not to return to therapy, it is important that you come in for a final session, so that we can discuss the reasons leading to the decision, the course of therapy and any relevant referrals. A case is considered terminated when there is no longer any regular sustained contact following a specified treatment plan.

**STATEMENT OF UNDERSTANDING:** I understand the above information and/or have discussed any questions related to the above information to my satisfaction. By signing this agreement, I agree to the terms and conditions outlined herein and have had the opportunity to ask questions and/or discuss concerns.

**PAYMENT:** Our fees are based on a therapeutic hour of 50 minutes for psychotherapy services. We accept cash, checks, or credit/debit cards. We will charge a fee of \$25 dollars for every returned check. If you fail to cancel your appointment within two days in advance, you will be charge the full session amount. You will have to pay that session at the beginning of your next appointment or call us to provide your card information. We will try to contact you two days in advance to remind your appointment, but it is your responsibility to cancel or reschedule the appointment on time.

### **Technology Statement**

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies:

**Cell phones:** It is important for you to know that cell phones may not be completely secure or confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with your therapist.

**Text Messaging and Email:** Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. We realize that many people prefer to text and/or email because it is a quick way to convey information. However, please know that it is our policy to utilize these means of communication strictly for appointment confirmations (nothing that could be inferred as therapy). Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that your therapist will not respond. You also need to know that we are required to keep a summary or a copy of all emails and texts as part of your clinical record that address anything related to therapy.

**Facebook or Social Media** It is our policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Instagram, etc. because it may compromise your confidentiality. The Counseling Institute of Atlanta has a business Facebook page and LinkedIn. You are welcome to follow us on any of these pages. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to The Counseling Institute of Atlanta. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

**Google, Bing, etc.:** It is our policy not to search for our clients on Google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself to your therapist as you feel appropriate. If there is content on the Internet that you would like to share with your therapist for therapeutic reasons, please print this material and bring it to your session.

**Faxing Medical Records:** If you authorize us (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, we may need to fax that information to the authorized entity. It is our responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of our fax machine. However, our fax machine is kept behind two locks in our office. And, when our fax machine needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

**Recommendations to Websites or Applications (Apps):** During the course of treatment, your therapist may recommend that you visit certain websites for pertinent information or self-help. She or he may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to your therapist if you would like this information as adjunct to your treatment or if you prefer that your therapist does not make these recommendations.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

### **In Case of an Emergency**

The Counseling Institute of Atlanta is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911
- Go to the emergency room of your choice

**Informed Consent for special Circumstances**  
**Adolescents 16 - 18 years old and some College Students**

At these ages in the State of Georgia, confidentiality as a privilege belongs to the client. I am aware that in most cases, children may still be legally dependent, living at home, and that parents are likely paying for therapy; nonetheless, this is the law. Therefore, I must have the written consent of the client to communicate with parents regarding issues related to their treatment.

It is my philosophy to facilitate communication between adolescents and their families and I will attempt to bring parents' concerns into the therapy. When I deem it clinically important, periodic family meetings will be requested.

If an adolescent client is engaged in risk taking or potentially dangerous behaviors, I operate under the same principles that apply to adult clients, working toward therapeutic remediation of the behavior(s) in question. The dangerousness of the behavior(s) is a point of clinical judgment and in circumstances in which an adolescent refuses to cooperate with treatment recommendations to correct the behavior, it may be necessary to breach confidentiality for their protection and in rare occasions terminate treatment.

Information received from parents via phone calls, voice mail, and/or any written communication will not generally be kept secret as this impedes the therapeutic process and relationship.

I understand the above information and/or have discussed any questions related to the above information to my satisfaction.

**Our Agreement to Enter into a Therapeutic Relationship**

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.

By signing this agreement, I agree to the terms and conditions outlined herein and have had the opportunity to ask questions and/or discuss concerns.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist, and you are authorizing your therapist to begin treatment with you.

\_\_\_\_\_  
**Client Name (Please Print)**

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

**If Applicable:**

\_\_\_\_\_  
**Parent's or Legal Guardian's Name (Please Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent's or Legal Guardian's Signature**

The signature of the therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

\_\_\_\_\_  
**Therapist's Signature**

\_\_\_\_\_  
**Date**





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## **NOTICE OF PRIVACY PRACTICES** **WRITTEN ACKNOWLEDGMENT**

My signature acknowledges that I have received a copy from the Counseling Institute of Atlanta, Inc. of the Notice of Policies and Practices to Protect the Privacy of Your Health Information. This notice details the policies that protect the privacy of my personal health information. I consent to the use and disclosure of my protected mental health information by the Counseling Institute of Atlanta, Inc. for the purpose of providing treatment to me, obtaining payment for the mental health services provided, and/or to conduct other counseling services. I understand that I may ask questions and discuss any concerns that I might have regarding these policies and practices with the staff of the Counseling Institute of Atlanta, Inc.

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

Client's printed name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature of Parents/legal guardian \_\_\_\_\_ Date \_\_\_\_\_

Parent's printed name \_\_\_\_\_ Date of Birth \_\_\_\_\_



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## Authorizations

### **Verification of Information**

My signature means that I am providing the information related to my case / my child’s name. I affirm that all the information that I have provided and that the evaluator has obtained is true and correct. I am the only one responsible for providing the information contained in this clinical history.

### **Confidentiality**

This is a strictly confidential patient/ examinee or client psychological record. Redisclosure or transfer without the client’s or examinee written consent is strictly prohibited, except as permitted by the law.

The client understands that secure and private communication cannot be completely guaranteed through cellphones and e-mail. It is the decision of the client to communicate, or not, through these “non-secure” technologies. If the client uses these “non-secure” technologies to contact the counselor, the counselor will communicate with the client through these “non-secure” technologies as well, until the client indicates otherwise. Please, indicate what type of communication is allowed:

Communication via phone or cell phone _____	Communication via voice message _____
Communication via fax _____	Communication via e-mail _____
Communication via text message _____	Communication via teleconference _____

### **Authorization for release of information**

If my case or my child’s case is of a legal nature, I authorize the release of information related to my case to my probation and parole officer, my attorney or legal counsel, the court and its agents, DFCS, or any other agency or entity legitimately related to my case. I will be informed by my therapist in case of any request for information.

\_\_\_\_\_

Client’s signature

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Parents/legal guardian

\_\_\_\_\_

Date



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## **CANCELLATION AND MISSED APPOINTMENT POLICIES**

Our fees are based on a 50-minute session for psychotherapy services. We accept cash or credit / debit cards. If you do not cancel your appointment within two days in advance, you will be charged the full fee for the session. The responsible parent or guardian will have to pay for that session at the start of their next appointment or call us to provide their card information; Note that we will try to contact you two days earlier to remind you of your appointment, but it is your responsibility to cancel or reschedule the appointment in time.

Thank you for your understanding and cooperation.

My signature below accepts that I understand and accept the terms and conditions of this rule.

\_\_\_\_\_

Client's signature

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Parents/legal guardian

\_\_\_\_\_

Date