Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services
5855 Jimmy Carter Blvd., Suite 200, Norcross, GA, 30071
Office: (404) 630-1361 / Fax: (770) 441-9177

CHILDREN INTAKE FORM (4-12 years old)

I- DEMOGRAPHIC INFORMATION

Child's name:_____ Today's date: _____

Age: _____ Date of birth:_____Place of birth (city and country)_____

Address:_____City:_____State:_____

(Parents or legal guardian's information):

Mother: _____ Age: _____ Phone: _____

Please indicate any restriction for phone calls: _____

Can we leave a text/voice message? Yes [ ] No [ ]

Address: _____ Place of Birth: _____

Father: _____ Age: _____ Phone: _____

Please indicate any restriction for phone calls: _____

Can we leave a text/voice message: Yes [ ] No [ ]

Address _____ Place of Birth: _____

If parents are separated or divorced, how long have you been separated or divorced, how old was the child, and how do you think this impacted him/ her?

_____

_____

How long have you been living in the United States?_____ How long in the state of Georgia? _____

Referred by: _____ Reason: _____

Informant _____ Relationship to Patient: [ ] Mother [ ] Father [ ] Other _____

Person(s) to contact in case of emergency:

Name: _____Telephone number: _____

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 [ ] Other _____

List information of your other children and brothers/sisters of your child and the other people living at home:

Name	Relationship	Age
1.		
2.		
3.		
4.		
5.		
6.		
7.		

How would you describe your child's relationship with his/ her mother?_____

_____

How would you describe your child's relationship with his/ her father?_____

_____

Please describe your child's relationship with his/ her grandparents: _____

_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life:

_____

_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his/ her siblings?_____

_____

_____

II- REASONS TO LOOK FOR COUNSELING

What problem motivated you to seek help for your child? _____

_____

_____

What are your/your child's goals for therapy? _____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?

_____

_____

_____

III- MEDICAL/MENTAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses your child has had:

_____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons):

_____

_____

Does your child have vision problems? [ ] Yes [ ] No Hearing problems? [ ] Yes [ ] No

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons):

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

_____

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

If affirmative, please describe:_____

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/was abusing him / her? _____ When did it happen?_____

Did anybody report it to DFCS? Yes [ ] No Who reported it? _____

IV- CURRENT SYMPTOMS OR BEHAVIORS CHECKLIST

Only checked those that apply to your child:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			Tantrums →			Nausea →		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues Re: Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting His/Her Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

V- DEVELOPMENTAL HISTORY

Problems during Pregnancy, Birth, and Childhood:

_____

_____

_____

VI- SOCIAL SUPPORT, SELF-CARE, AND EDUCATIONAL HISTORY

Child's current level of satisfaction with friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

How would you describe your child's relationships with his/her peers? _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Please briefly describe your child's self-care and coping skills: _____

_____

_____

What are your child's diet, weight, and exercise/activity patterns?_____

_____

_____

What are your child's hobbies, talents, and strengths?_____

_____

_____

Please briefly describe your child's school performance and experience:_____

_____

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 What Program? _____

What are his/her grades? _____

Failing or low grades in the following subjects: _____

Has your child presented behavioral problems at School? Has he/she been expelled or suspended from school?

_____

_____

Additional Information:

_____

_____

_____

_____

_____

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PLEASE READ AND SIGN THE FOLLOWING PAGES

Counseling Institute of Atlanta, Inc.

Bilingual & Multicultural Mental Health Services

INFORMED CONSENT FOR COUNSELING SERVICES WITH CHILDREN

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 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 or (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 both of 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. I agree not to subpoena therapy records in the event of a legal proceeding.

PAYMENT: Our fees are based on a therapeutic hour of 50 minutes for psychotherapy services. We accept cash or credit/debit cards. If you fail to cancel your appointment within two days in advance, you will be charged 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.

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.

Parent's / Legal Guardian's Signature: _____Date: _____

Parent's / Legal Guardian's Signature: _____ Date: _____

Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services

INFORMED CONSENT FOR SPECIAL CIRCUMSTANCES CHILDREN AND ADOLESCENTS AGES 15 AND UNDER

At these ages, child clients are considered dependent minors and confidentiality belongs to the legal parent/guardian(s). It should be explained to the child that there is a difference between privacy and confidentiality; therefore, a child can expect that their communications are kept private unless (in the judgment of the therapist), parents need to be informed of a particular issue or circumstance that poses a direct threat or risk to the safety of the minor in question. Examples might include (but are not limited to): at risk behaviors such as substance abuse, medical issues, family dynamics, or other situations in which the parents may be needed as a therapeutic resource. It is my general philosophy to use a model in which parents can serve as consultants in the therapy of children fifteen years and under.

Children of divorced/separated parents: Although these situations can be difficult and delicate, there are certain legal and ethical guidelines that I follow:

- Consent for treatment must be obtained from both parents unless legal custody is documented. I will require that a copy of this document be kept in my file reflecting the custodial parents control to make medical decisions on behalf of the minor.
- Unless sole custody is established, both parents have the right to communicate with me regarding treatment issues. I have the right to communicate with either/both parents regarding treatment issues based on my clinical judgment. All written communication will be copied to both parents.
- Because the child is the client, it is my job to work as an advocate for the welfare of the child. Unresolved marital conflicts may require treatment in another therapeutic setting.

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

Parent's / Legal Guardian Signature: _____ Date: _____

Parent's / Legal Guardian Signature: _____ Date: _____

Counseling Institute of Atlanta, Inc.
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NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT

My signature acknowledges that I was informed and 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.

Parent's / Legal Guardian Signature: _____ Date: _____

Parent's / Legal Guardian Signature: _____ Date: _____

Counseling Institute of Atlanta, Inc.
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AUTHORIZATIONS

Verification of Information

My signature means that we are providing the information related to my child's case. I affirm that all the information that we have provided and that the evaluator has obtained is true and correct. We are the only responsible for providing the information contained in this clinical history.

Confidentiality

This is a strictly confidential patient/ examinee or client mental health 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 the case is of a legal nature, we authorize the release of information related to this case to probation and parole officer, attorney or legal counsel, the court, and its agents, DFCS, or any other agency or entity legitimately related to the case. We will be informed by the therapist in case of any request for information.

_____ _____
Parent's / Legal Guardian Signature Date

_____ _____
Parent's / Legal Guardian Signature Date

_____ _____
Therapist or Examiner Date

Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services

CANCELLATION AND MISSED APPOINTMENT POLICIES

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed a full session fee for your missed appointment.

You will be automatically charged a full session fee for any missed appointments that are cancelled with less than a 2-day notice. This fee may be waived in cases involving emergencies, but such a waiver is solely at my discretion. A bill will be mailed directly to all clients who do not show up for the appointment or cancel an appointment on time.

Thank you for understanding and cooperation.

The signature below acknowledges that I understand and accept the terms and conditions of this policy.

_____ _____

Parent's / Legal Guardian Signature Date

_____ _____

Parent's / Legal Guardian Signature Date