AnneMarie Murdock MA, LMFT

Child Intake Form (For Parent/Guardian of child under 13 years)

Client Information

Today's Date: ______________________ Referred by: ______________________

Child's Name: ______________________ Age: __________

Date of Birth ______________ Grade: ________ Does the child attend church? ☐ Yes ☐ No

Child's Custodian/Guardian is/are: ______________________

Child's Address: ______________________ Apt #: __________

Ciy: ______________________ State: __________ Zip Code: __________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Cell Phone #2: ______________________

Email Address: ______________________

Child lives with: ☐ Bio-Mom and Dad ☐ Bio-Mom only ☐ Bio-Father only ☐ Adoptive Parent(s)

☐ Bio-Mom & Step Parent/Boyfriend/Other ☐ Bio-Father & Step Parent/Girlfriend/Other

☐ Foster Care Provider ☐ Other: ______________________

Legal Custody is with: ______________________

Father's Information

Father's Name: ______________________________ Age: ________

Father's Address: ______________________________ Apt #: ________

City: ________________ State: ________ Zip Code: ________
Cell Phone: ________________ Email Address: ________________

Occupation: ______________________________

Employer: ______________________________

Father's Marital Status: ☐ Married ☐ Engaged ☐ Widowed ☐ Divorced ☐ Separated

☐ Live with Partner ☐ Other: ______________________________

Mother's Information

Mother's Name: ______________________________ Age: ________

Mother's Address: ______________________________ Apt #: ________

City: ________________ State: ________ Zip Code: ________

Home Phone: ________________ Work Phone: ________________

Cell Phone: ________________ Email Address: ________________

Occupation: ______________________________

Employer: ______________________________

Mother's Marital Status: ☐ Married ☐ Engaged ☐ Widowed ☐ Divorced ☐ Separated

☐ Live with Partner ☐ Other: ______________________________

Family Composition

Who currently resides in the same house as the child? Please include EVERYONE including any half or step siblings. Please indicate their full name, age and relationship to the child, use the back of this page if you need more room.

Name	Age	Relationship
1. ______________________	______	______________
2. ______________________	______	______________
3. ______________________	______	______________
4. ______________________	______	______________

Client's Medical and Personal Information

Has your child had counseling before? ☐ Yes ☐ No When? ______________________

Counselor/Therapist Name: ______________________________

What was your child's experience of therapy like?____

____

Diagnosis:____

Date of last medical exam: ______________________________

Please rate your child's health: ☐ Excellent ☐ Good ☐ Average ☐ Poor

Has your child ever been hospitalized? ☐ Yes ☐ No If so, please explain below.

Is your child on medication? ☐ Yes ☐ No If so, please provide the following information, use the back of this page if necessary.

Name of Drug	Dosage	For what?
1.		
2.		

Does your child have an addiction? ☐ Yes ☐ No ☐ Uncertain If so, please explain below.

Has your child had any previous trauma? ☐ Yes ☐ No ☐ Uncertain If so, please indicate what kind:

☐ Physical ☐ Emotional ☐ Sexual ☐ Abortion ☐ Witness to crime ☐ Victim of crime

Has your child ever been arrested? ☐ Yes ☐ No If so, for ____________________

Basic Information

What concern has caused you to bring your child in for counseling at this time?

What has been done about your concern up to this present time?

Has anyone in the family experienced similar problems?

What are some of your child's strengths?

How would your child describe the problem?

What is the current family situation?

How do the parents relate to each other?

Describe the style of discipline that you use with your child?

What are your expectations for your child?

In what ways is your child different from other members of the family?

How does your child handle stress?

In the last two weeks, have you been concerned that your child might hurt themself, or someone else?

Is there any other information you think we should know about?

DISCLOSURE STATEMENT for Children

AnneMarie Murdock, MA, LMFT. Mailing and physical Address: 503 Van Trump Ave NW, Yelm, WA 98597

Cell/text: (360) 481-3660; e-mail: annemarie@yelmprairiecounseling.com

If an emergency arises and you cannot contact me, contact the Crisis Clinic at (360) 586-2800, OR call 911, OR go directly to St. Peter's Hospital Emergency Room

Therapist's Credentials

Masters in Counseling and Psychology, LMFT and NCC. Additional training and experience in Domestic Violence Advocacy, and Equine Therapy.

Therapist's Education, Training, and Experience: MA from St Martins University (2016) in Counseling Psychology. BA from Evergreen State College (2005) in Health and Human Development and Contemporary Social Issues. Over 30 years' experience in Equine Facilitated Therapy. Child and Family therapist internship completed at Greater Lakes Mental Health Care. Safe Place Advocate Volunteer, 2014.

Therapeutic Orientation and Treatment Modality (Techniques Used):

My interests are Child and Youth therapy, Families, and Couples. Together, we work to identify and process feelings and behavior patterns, and continue the journey toward more useful behaviors and thought patterns. My style is warm and positive, and my hope is to give you tools to make the changes you desire. I believe strongly that you are the expert on your life. I use play and expressive therapy, Family Systems and Cognitive Behavioral approaches.

Course of Treatment: Since each person's situation and needs are different, at this time I do not know what will be the best course of treatment for you. However, we will discuss treatment options as we become more familiar with each other. If you decide to terminate therapy, please let me know. I appreciate feedback, and would like to have the opportunity to give our time together some closure. You are also welcome back at any time in the future, should you wish to return for more therapy.

Client's Cost Per Session: ***I do not currently accept insurance.*** The fee is $100 for an individual 50-minute session and $120 for a family session. Clients are asked to make payments, by credit, ACH transfer, or cash at the beginning of each session, unless other arrangements are made. It is possible that if you have insurance you may receive some reimbursement with a 'super bill' which I can email on request. It is your responsibility to find out what your insurance covers, and to submit the paperwork for reimbursement. Writing reports, lengthy phone calls, and running overtime in individual sessions is charged at a rate of $100/hour. Overtime charges are $120/hour for Family sessions In the event of an unpaid bill, your name, address, phone numbers, social security number, date of birth, dates of service, and payment record may be disclosed to a collection agency or small claims court. In such incidents, I would, of course, attempt to notify you before taking such action.

Missed appointments

I understand that things happen and we can't always make an appointment. Please know that I have scheduled this time for you, and if you cannot make it, I expect to be notified 24 hours in advance. If you miss an appointment without notifying me beforehand, I may charge the fee for the missed appointment; which must be paid prior to your next appointment.

Legal Statements and Issues: Washington State law requires Licensed Therapists to provide clients with certain information about their rights and responsibilities (see WAC 246-809-710). This subsection does not grant (clients) new rights and is not intended to supersede state or federal laws and regulations, or professional standards. You have the right to refuse treatment and the right to choose a practitioner and treatment modality that best suits your needs. If you wish to obtain a list of the acts of unprofessional conduct listed in the laws (RCWs), you may contact the Department of Health at:

Washington State Department of Health (360) 236-4030 101 Israel Road SE, Tumwater, WA 98501 (or: PO BOX 47890, Olympia, WA 98504-7890) or visit: http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130.180

Confidentiality and Releases of Information:

If you are age 13 or older, you have the same rights of confidentiality as an adult. Without your permission and a release of information document signed by you, I cannot share with your parent(s) anything we talk about.

If your child is under the age of 13, parents are entitled to any information regarding therapy and treatment.

I keep a record of the health care services that I provide to you. You may ask to see and copy that record. You may also ask me to correct that record. I have an ethical and moral responsibility to protect your confidentiality and I will not normally disclose your records to others. However, there are some limits to that protection. First, in some instances you may wish me to share information another person (attorney, minister, or another health-care provider). In such cases, you will be asked to sign a "release of information" form. Second, I may be required by law to disclose your confidentiality information. ***This would occur only in the following instances:***

1) If I have reason to believe your or someone else's life and safety is threatened or endangered.

2) If there is evidence, or even suspicion, of physical or sexual abuse or neglect of a minor child or vulnerable adult (dependent, developmentally disabled, or incapacitated person). I must, by law, report all incidents of past or current abuse or neglect of children or vulnerable adults. I must also report serious threats against another person and serious suicide intentions.

3) As part of good professional practice, there are times when I consult with colleagues on various therapeutic issues. When I do, it is with considerable caution and I do not disclose any identifying information about you.

4) If a judge orders certain information disclosed in a legal proceeding. In legal proceedings when your psychological health is at issue (e.g. work related stress, divorce, custody battles, etc.) the attorney for the opposing side may have certain information subpoenaed. In that case, I would inform you of the subpoena and if you objected to my complying, you would have 14 days to seek a protection order to contest the subpoena. I cannot contest it for you and I may still be required to release the information.

Your signature will verify that you have read and understand the information in this Disclosure.

.____.

Client signature   Date

.____.

Signature of Legal Guardian (if under 13 years of age)   Date

Consent For Transmission Of Protected Health Information By Non-Secure Means

I consent to allow AnneMarie Murdock to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments.
- Information related to billing and payment.
- Agreed upon resource information.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

.____.

Client or Legal Guardian (under age 13) Date