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CHILD/ADOLESCENT COUNSELING INTAKE FORM

FORM TO BE COMPLETED BY PARENT/GUARDIAN

Parent Name_____ Date _____

Child/Adolescent Name_____ Date of Birth _____ Age ____

The child is currently living with: _____

Home Address _____
Street City State Zip
Phone(h) _____ Phone(c) _____ Phone (w) _____

Email Address _____

Parent Current Marital Status: Single ___ Married ___ Separated ____ Divorced ___ Widow(er) ____

Spouse's Name: _____

Child(ren)'s Names: _____ Date of Birth: _____ ☐M ☐F

_____ Date of Birth: _____ ☐M ☐F

_____ Date of Birth: _____ ☐M ☐F

How did you hear about this counseling office: _____

RELIGIOUS BACKGROUND

Religious Affiliation: _____ ☐Active ☐Inactive

How significant is your religion to your everyday life? _____

MEDICAL HISTORY

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

Date of last physical exam:_____ Physician: _____

Is your child currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems):

☐Yes ☐No If yes, please explain:_____

Medications (Over-the-Counter or Prescription)	Dosage	Reason for Medication

Has your child ever had surgery? If yes, for what reason? _____

Primary Care Physician: _____ Last Seen: _____

Please list any learning disabilities: _____

COUNSELING AND PSYCHIATRIC HISTORY

Has your 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? _____

REASONS FOR SEEKING HELP (use the back of this page if needed)

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

_____

Where are these concerns causing the most problems?
Check all that apply: ☐ Home ☐ School ☐ Work ☐ Other

What do you hope your child gains from counseling? _____

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

- ❑ Lack of motivation
- ❑ Excessive fears or anxieties
- ❑ Feeling lonely
- ❑ Angry feelings
- ❑ Difficulty being away from specific family members
- ❑ Loss of interest in usual activities
- ❑ Hearing voices
- ❑ Nightmares
- ❑ Difficulty falling asleep/inability to sleep all night
- ❑ Decreased/Increased appetite
- ❑ Hyperactivity
- ❑ Temper Tantrums
- ❑ Bullying/picking fights
- ❑ Refusal to respond to authority
- ❑ Getting into trouble at school/play
- ❑ Obsessions/compulsions with specific activities
- ❑ Crying spells
- ❑ Lack of self confidence
- ❑ Difficulty making or keeping friends
- ❑ Other: _____

OTHER PERTINENT INFORMATION (use the back of this page if needed)

_____

_____

CONSENT FOR COUNSELING OF MINORS (AGE 17 & 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 _____

DISCLOSURE STATEMENT

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

DESCRIPTION OF COUNSELING

My counseling philosophy is holistic in that three interrelated perspectives are explored in counseling: the Existential (the person), the Situational (his/her world), and the Normative (his/her God). Based on your counseling needs, you may be advised to take appropriate tests/inventories or seek medical treatment to facilitate the counseling process. I adhere to the Code of Ethics prescribed by South Carolina Code of Ethics for Mental Health Professionals and the American Association of Christian Counselors. If you would like a copy of these codes, please ask for one.

REFERRAL POLICY/DISCLAIMER

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

Once an intake evaluation has occurred, a chart will be opened as a new client. Any chart that has not been active in one year will be considered inactive and the chart will be closed and you will no longer be considered a current client.

FINANCIAL POLICY AND INFORMATION

Initial Evaluation fee is $160. The fee for a 50-minute session is $125. The fee for an 80-minute session is $160. Payment is due at the beginning or the end of each session and accounts must be kept current in order to continue counseling. Cash, checks, and some credit cards are accepted forms of payment (there is a $30 charge on all returned checks.).

Jodi G. Dunphy, MA LPC LLC is not in network with any insurance providers. If you would like to file out of network, a form will be provided to you at the end of each session. Payment is due at time of service.

CONFIDENTIALITY

Generally speaking, information provided by and to a client in a professional relationship with a counselor is legally confidential. By law, information can only be released with the written consent of the client and only to parties specified by the client. There are specific exceptions to your right to confidentially which include: 1) Any suspected incident of child abuse or neglect; and 2) Imminent danger to self or others. When consulting with parents regarding minor children, specific content of therapy sessions with children or adolescents will be held in confidence unless their welfare requires that the parent(s) have access to such information. In most cases, joint meetings between children and/or adolescents, their parents and the therapist will be arranged as a part of the therapy process.

CANCELLATION POLICY

I request that you notify 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 sudden illnesses and emergencies only.

CONTACTING YOUR COUNSELOR

For scheduling and canceling your appointments, you must contact my office directly. For emergencies after hours, please contact 911 or go to your nearest emergency room.

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

_____ _____

Client/Guardian Signature Date

Disclosure Statement – Client Copy

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ADOLESCENT COUNSELING INTAKE FORM

TO BE FILLED OUT BY TEEN (AGES 13-17) AND INCLUDED ALONG WITH THE CHILD/ADOLESCENT FORM

Name_____ Date of Birth _____

Address _____City, State, Zip _____

Email Address _____

Who are you presently living with? _____

School: _____

Hobbies: _____

Job (if none, leave blank): _____

What concerns have brought you into counseling today? _____

_____

PROBLEMS CHECKLIST

Please rate each issue with a number: 1=Major Problem 2=Sometimes a Problem 3=Never a Problem

_____ Feeling accepted by my peers

_____ Learning how to trust others

_____ Feeling bad about the way I look/my body

_____ Getting along with my parents or other family members

_____ Getting a clear sense of what I value

_____ Worrying about whether I'm normal

_____ Dealing with sexual feelings and/or problems

_____ Excessive worry or anxiety

_____ Difficulty with social media

_____ Trying to decide on a career

_____ Never eating / eating too much and vomiting to control weight

_____ Dealing with my alcohol or drug abuse

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

Are there any other problems or concerns you would like to address?_____