**Welcome to**

**3G COUNSELING AND ASSESSMENT**

**CHILD INTAKE FORM**

Child’s First Name: \_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_

Birthday: Month: \_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: \_\_\_\_\_\_\_\_\_\_\_Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex/Gender:\_\_\_\_\_\_\_\_\_\_\_\_

Name of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your relation to the child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of other parent/legal guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Home address: Whom does your child live with? Are both parents living in the home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If not, please list the name and number of the other parent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the requested service in relation to a child custody case? Yes /No

Is there an open CPS case for this child/ Yes/No

Is the child adopted? Yes/ No

                                 **PAYMENT INFORMATION**

 Please provide a copy of insurance card and photo ID.

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Id Number\_\_\_\_\_\_\_\_\_\_\_\_

 Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Information\_\_\_\_\_\_\_\_\_\_

Full name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_ Gender: \_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_

Client’s relationship to insured (circle): Self Spouse Child

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_

Cell Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_ Other: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a second insurance policy (circle) Yes No I don’t know (If yes, we will need a copy of that insurance card.)

EMERGENCY CONTACT: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Number:\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child currently receiving treatment for an illness, injury, or other medical condition? Yes/ No If yes, what is the diagnosis and what are the treatments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child currently taking any prescription or over-the-counter medications or illegal drugs? Yes/ No If yes, please tell us the name and dosage of each medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your or the child’s goals for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

**ACADEMIC INFORMATION:**

 Name of Child’s School: \_\_\_\_\_\_\_\_\_ School District:\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_

**Academic services received by the child**. Circle all that apply.

504 BIP Special Education Services Speech Services Gifted and Talented

Other: \_\_\_\_\_\_\_\_\_\_

**HOW INTENSE IS YOUR CHILD’S EMOTIONAL DISTRESS?**

Overall, how much do the problems affect your child’s ability to perform school, get along with others, and perform daily tasks such as chores?

(Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)

Please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did these problems start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was going on in your child’s life at that time?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle ALL of the following items that are currently a concern regarding your child:**

High Anxiety Academic Struggles Anger Management Low Self Esteem

Conflict Resolution Childhood Emotional Abuse Childhood Physical Abuse

School behavior Issues Depression Stealing ADD/ADHD Family Issues

Grief/Loss Loner Cutting/self-mutilating behaviors Physical abuse/violence

Stress Suicidal Ideation Homicidal Ideation Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT AND POLICIES**

Please initial on each line.

\_\_I understand that the counselor will develop a treatment plan consisting of goals I have for my child, goals my child may have, and those the counselor determines are in the best interest of my child.

\_\_I understand that Wanda S. Cook is a Licensed Professional Counselor in the state of Texas.

\_\_I understand that Wanda S. Cook works with children, adolescents, and adults in individual, group and family counseling.

\_\_\_ I give permission to Wanda S. Cook to provide services to my child who is a minor.

 \_\_I understand that I am in control of the counseling relationship regarding my child and may choose at any time to end the therapeutic relationship.

\_\_I understand that no promises have been made to me as to the results of treatment.

\_\_I am aware that I may stop treatment at any time, however, I agree to talk with the counselor if I feel like ending therapy before all the treatment goals for my child are met.

\_\_I understand that if any assignment is given to my child that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.

\_\_I understand that if I am concerned about slow progress or lack of progress, I have the right to speak to Wanda S. Cook about this.

\_\_I understand that counseling can improve as well as upset the equilibrium in any person or family.

\_\_I understand that if I have a complaint I can not resolve with Wanda S. Cook and I wish to file a formal complaint, I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

\_\_I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to Wanda S. Cook.

\_\_I am responsible for paying my co-payment at the time of my session.

\_\_I understand that there is a returned check fee of $40.

\_\_I understand that all copays are due at the time of service.

\_\_I understand that if I do not give at least 24 hours notice in canceling an appointment, I will be charged a fee equal to that of the scheduled appointment. This amount, which will not be covered by insurance, will be due not later than the next scheduled appointment.

\_\_I understand that the rate for each session is $120 per hour for individuals and $125 per hour for family sessions.

\_\_I understand that Wanda S. Cook is not a psychiatrist and is a Master’s level counselor, and as such can not recommend or prescribe medications but can encourage clients to see an MD for a medication evaluation.

\_\_**Emergencies**: I understand that Wanda S. Cook **does not** provide formal emergency services. If my child is in an urgent situation, I have the choice of calling 911, or taking my child to the nearest emergency room for immediate care.

\_\_Confidentiality is the ethical right of all clients. However, there are certain exceptions, which surpass the confidentiality of the client-counselor relationship and the counselor may be ethically bound and legally required to inform the proper authorities.

**Exceptions to Confidentiality**:

1. The counselor makes an assessment that the client is a danger to self or others.

2. A client reports past or present abuse/neglect/exploitation of a child, elderly person, or a person with a disability (physical or intellectual).

3. A client acknowledges committing past or present abuse/neglect/exploitation of a child, elderly person, or a person with a disability (physical or intellectual).

4. When counseling records are subpoenaed by a court of law.

5. The client shares with the counselor their use of pornography involving minors.

By signing below, I confirm that I have read, agree to, and received the above information.

Name of Child:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_