MONICA BUTTAFAVA M.S., LMHC
CHILD AND ADOLESCENT PSYCHOTHERAPY
561.962.1976

CHILD INTAKE/HISTORY FORM

Child's Name_____

Date_____

Age_____ Birthdate_____

Grade_____ School

_____

Home Street Address

_____

City _____ State _____ Zip Code

_____

Home Ph# _____ Cell Ph#

_____

Email Address _____

PARENTS / PRIMARY CARETAKERS

Mother's Name _____ Age/DOB

_____

Father's Name _____ Age/DOB

_____

Does your child have other parents (s) / Stepparent (s)?

_____

_____

_____

Name/Age of siblings

_____

Who lives in the household with the child currently?

Are there any significant family or marital conflicts?

PRESENTING PROBLEM

What are the concerns or difficulties that cause you to seek professional help at this time?

DEVELOPMENTAL HISTORY

Infancy / Early Development

Did the child have colic or significant irritability? No _____ Yes

Was there any feeding difficulties? Sleeping difficulties?

_____

Was the child normally active? _____

Was the baby able to gain weight and grow normally?

_____

Was early development significantly different from the child's sibling? (if applicable)

_____

_____

_____

_____

Early Developmental Milestone History

Were language, motor, and social milestones achieved within normal limits?

_____

_____

_____

_____

Past Therapeutic Services (i.e. Speech, Occupational, Behavioral)

_____

_____

_____

_____

_____

MEDICAL HISTORY

What is your child's present health? Excellent _____ Good _____ Fair

Has the child had any serious illnesses, injuries or other health problems?

Is the child currently taking any medications?

Does the child have a special diet or is he/she taking dietary supplements?

Are there any specialty physicians involved in the child's care?

BEHAVIORAL/EMOTIONAL CONCERNS:

Does your child exhibit any of the following behaviors? Are any of the behaviors of particular concern?

☐ Short Attention sensitive	☐ Cruelty to Animals	☐ Food Refusal	☐ Sensory
☐ Distractible Interests	☐ Fire Setting	☐ Pica	☐ Restricted
☐ Hyperactive Behaviors	☐ Oppositional/Defiant	☐ Self-Injury	☐ Repetitive
☐ Impulsive	☐ Lying	☐ Head Banging	☐ Poor Eye

Contact

☐ Sleep Problems
☐ Temper Tantrums
☐ Aggressive
☐ Destructive
☐ Attention Seeking
☐ Fearless
☐ Mood Swings
☐ Social Anxiety
☐ Stranger Anxiety
☐ Separation Anxiety
☐ Excessive Crying
☐ Excessive Laughing
☐ Noncompliant
☐ Stealing
☐ Truant
☐ Sexualized Behaviors
☐ Masturbates
☐ Peer Problems
☐ Hallucinations
☐ Mood Lability
☐ Suicidal Thoughts/Attempts
☐ Anorexia
☐ Binging/Purging
☐ Self-Stimulation
☐ Hand Flapping
☐ Peculiar Habits
☐ Toe Walking
☐ Nail Biting
☐ Ritualistic
☐ Need for Routine
☐ Literal

Comments:

Has your child ever experienced any traumatic events (e.g., death of a close relative or friend,

accident, etc.)? If yes, please describe

_____

_____

_____

_____

Is there a history of physical or sexual abuse, family violence or neglect? Yes_____

No_____

If yes, please explain

_____

Has your child ever had counseling, psychotherapy and/or psychological testing?

_____

If yes, date(s)

_____

Agency or name of doctor/

therapist(s)_____

Has your child ever seen a psychiatrist or received medication for behavior, attention or emotional problems?

_____

If yes, date(s), name of prescribing doctor and medication

_____

Type of Discipline used in the home?

_____

Who is the primary disciplinarian?

_____

Is discipline generally effective?

_____

EDUCATIONAL HISTORY

Does the child have an Individualized Educational Plan (IEP)?

_____

Has the child ever repeated or skipped any grades?

_____

Have the teachers reported problems in any of the following areas? If so, please explain

☐ Reading	☐ Attention/Concentration
☐ Spelling	☐ Hyperactivity
☐ Math	☐ Behavior
☐ Writing	☐ Social Adjustment

_____

_____

_____Please describe how your child gets along with other students at school:

_____

_____

_____

_____

How does the child get along with teachers?

_____

History of suspensions/detentions/behavior difficulties?

_____

SOCIAL HISTORY

How does the child get along with peers?

_____

Does the child get along with adults?

_____

Does the child understand social cues? (ex. When someone is angry)

_____

_____

_____

Is the child shy? _____ Around familiar individuals?

_____

Does the child prefer to be/play with others or alone?

_____

What are the child's extracurricular activities?

_____

What activities does the child enjoy?

_____

Has the child's social skills or relationships changed recently?

_____

Does the child become overly anxious or upset when separated from parents?

_____

FAMILY HISTORY

Has anyone in the **immediate** or **extended** family (of either parent) had any of the following problems?

☐Late Walking

☐Late Talking

☐Learning Problems

☐Mental Retardation / Intellectual Disability

☐Special Education

☐Speech Therapy / Speech Difficulties

☐Autism Spectrum Disorder

☐ADHD

☐Cerebral Palsy

☐Depression

☐Bipolar Disorder / Manic Depression

☐Schizophrenia

☐Mental Illness (other than those listed)

☐Other

Which family members can be involved in this child's case?

_____

Describe your relationship with your child. What do you do together regularly?

_____

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CLIENT INFORMATION

Client Legal Name:_____ DOB: ____/____/_____ Age: _____
Client Preferred Name:_____ Gender: _____
Address:_____
Home Phone: (_____) _____ Cell: (_____) _____
Client School Name & City:_____

Parent/Guardian Information
Name:_____ Relationship to client:_____
Address:_____
Phone: (_____) _____ DOB: ____/____/_____
Parent Marital Status: S M D Other_____

Second Parent/Guardian Information
Name:_____ Relationship to client:_____
Address:_____
Phone: (_____) _____ DOB: ____/____/_____
Parent Marital Status: S M D Other_____

How were you referred to me?_____

Insurance (please complete insurance form for both in-network and out-of-network)
☐ Private pay, no insurance use
☐ In-Network insurance (please verify coverage with your plan)
☐ Out-of-Network insurance

Please list all family members living in the home, starting with the client.

Name	Relationship to Client	Age	Gender

It is the responsibility of the client (or guardian) to keep this office informed of any changes in insurance, residency &/or phone number as soon as possible.

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CONSENT OF A MINOR CHILD

(The following statements provide your legal consent to and financial responsibility for counseling services to a minor child. These statements are important to protect the child, the parent/guardian/conservator, and the therapist. Please carefully review this information and sign where indicated. You are requested to discuss any questions you may have with the therapist.)

STATEMENT OF RESPONSIBILITY AND GRANT OF PERMISSION FOR THERAPY

I am the: Natural Parent: [ ] Legal Guardian: [ ] Managing Conservator of [ ]

_____

(Name of minor child)

I am legally responsible for the child named above and grant permission to Monica Buttafava to conduct therapy with this child.

I accept responsibility for the timely payment of all fees due to Monica Buttafava for services provided to this child.

Signature: _____Date:

DUTY TO WARN NOTICE

Monica Buttafava is committed to the confidentiality and privileged communication with all clients. There are, however, several exceptions. According to Florida Law, any evidence of child abuse must be reported to the authorities. If any individual intends to take harmful, dangerous, or criminal action against another individual, or against himself/herself, it may be the therapist's duty to report such action or intent.

Signature: _____ Date: _____

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Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit

treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about
a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment*** Your health information may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. If I wish to provide information outside of my practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** I may use and disclose your health information to obtain payment for services I provide to you as delineated in the Therapy Agreement.

- ***For Operations*** I may use and disclose your health information as needed in order to support business activities of this practice, including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with

third parties that perform various business activities (e.g., billing or typing services) provided there is a written contract with the business that requires it to safeguard the privacy of your PHI.

- ***Please understand that we will keep your health information private, but there are times when the laws permit and require me to use and share this information.***

Patient's Rights:

- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask me to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell me the reasons you want to make these changes, and I will decide if it is and if we refuse to do so, I will tell you why within 60 days.
- ***Right to a copy of this notice*** – An electronically copy is always available to be print from my website,. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

- ***Right to Release Information with Written Consent*** With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of **Florida** Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client/Legal Guardian Signature Date

_____ _____

Printed Name

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

_____ _____

Monica Buttafava, M.S., LMHC Date

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Agreement for Confidentiality of Individual Treatment

I understand that it is Monica Buttafava's role to provide therapeutic services so that my child might feel better and/or improve my functioning. Monica Buttafava's role is not intended to gather information for the courts or to make judgments related to my family.

Therefore, I agree that I will not call upon Monica Buttafava to provide treatment records or to testify in a future divorce or custody action. I understand that courts can appoint professionals who have had no prior contact with my family to conduct independent evaluations and make recommendations to the court.

I understand that it is Monica Buttafava's policy to have no court involvement in my case because that could harm our professional relationship and the psychotherapy process. Since I need to speak freely, my spouse is also agreeing never to ask Monica Buttafava to testify or have his records of my treatment in court.

By signing this form we are both agreeing not to use any of my therapeutic intervention records or testimony in any future court proceedings.

Signed:
_____ Date _____

Signed:
_____ Date _____