Parkwood Counseling Center
Clinical Counseling from a Christian Perspective

NEW CLIENT INTAKE FORM

Full Name: _____ Date: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Social Security Number: _____

Email: _____

Party Responsible For Payment: (if different from above)

Full Name: _____ Date: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Social Security Number: _____

Email: _____

CHILD INTAKE FORM

Chief Concern
Please describe the main concern that has brought you to counseling:

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:
What does your child do that you like? What does he /she do that other people like?

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Family History:
The name of the child's biological parents:

Mother:_____ Father:_____

Who has legal guardianship of your child?

Who does your child currently live with?

Names	**Ages**	**Relationship to child**

Who are your child's significant others NOT living with your child?

Names	**Ages**	**Relationship to child**

Please describe any past counseling that either your child or any family member has had.

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____ If yes, Please describe:

Education History:
What school does your child attend?

Address:

Phone:_____ Teachers Name:_____

Current Grade:_____

What does your child's teacher say about him/her?

Other schools attended (including Pre-school)

Has your child ever repeated a grade? If so which one(s)

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

☐Fighting ☐Lack of friends ☐Drug/alcohol ☐Detention ☐Suspension

☐Learning disabilities ☐Poor attendance ☐Poor grades

☐Gang influence ☐Incomplete homework ☐Behavior problems

Medical History:

What is the name of your child's medical doctor?

Address: _____ Phone:_____

Date of your child's last medical examination:

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, Please describe them:

Has your child experienced any of the following medical problems?

☐A serious accident ☐Hospitalization ☐Surgery

☐A head injury ☐High fever ☐Convulsions/seizures

☐Eye/ear problems ☐Meningitis ☐Hearing problems

☐Allergies ☐Asthma ☐Other

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so please describe:

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child your family?

CLINICIAN PATIENT AGREEMENT

By signing this form, you are giving permission for us to treat your child under 18 years of age.

Rights and Risks:

- You may ask questions about any aspect of the counseling process.
- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- Therapy is most effective when you are open and can speak honestly about your emotions and experiences.
- Therapy may include talking about emotionally provoking subjects and scenarios.

Confidentiality:

- Information shared by you in session will be kept confidential.
- Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
- I am required by law to disclose information pertaining to suspected child abuse, the inability to care for one's basic needs for food, clothing or shelter, and threatened harm to oneself or others.
- The court may subpoena counseling records.
- It is understood that information regarding treatment and diagnosis may be provided to an insurance company.
- You may want to discuss further limits or exceptions of confidentiality.

Appointments:

- All office visits are by appointment and may be scheduled through your counselor directly.
- Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes.

_____	_____
Signature of Client (Required for Youth 13+)	Date
_____	_____
Signature of Legal Guardian	Date
_____	_____
Signature of Clinician	Date=

Emergencies:

The **best phone number** during business hours is 904-357-0536. If you receive the voice mail, please leave a message with your name and phone number. Your counselor may be on the phone, in therapy with someone else, or out of the office. In a crisis situation, please call 911 ***or*** **go immediately to your local hospital emergency room.**

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Parkwood Counseling Center to

☐ **Obtain** ☐ **Release** ☐**Exchange**

the following written verbal electronic video audio information (check all that apply):

☐ Treatment plan ☐ Social History ☐ Psychiatric Evaluation
☐ Discharge Summary ☐ Psychological evaluation and test results
☐ Behavioral Observation ☐ Physical Exam ☐ Medical treatment
☐ Alcohol/drug treatment ☐ Other: _____

Information from the records of:

_____ To/From:_____
Client Name Agency Name

_____ _____
Address Address

_____ _____
(City, State, Zip) (City, State, Zip)

_____
Date of Birth

For the purpose of: ☐ to assist in the evaluation and treatment of the client
☐ Other (specify)

To Receiving Agency: PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibitied unless the client provides specific written consent for the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.

I acknowledge that I have read this authorization and fully understand its contents.

_____ _____
Signature of Client (Required for Youth 13+) Date

_____ _____
Signature of Legal Guardian Date

_____ _____
Relationship Telephone Number

_____ _____
Witness Date

This release shall be valid for

☐ a single disclosure
☐A continuing disclosure for 90 days
☐A continuing disclosure for 1 year

TO BE SIGNED TO REVOKE RELEASE OR TO INDICATE A REFUSAL TO SIGN:
Refusal to sign or revocation of this release in writing at any time is not a condition of treatment, payment, enrollment or eligibility for benefits.

_____ _____
Signature of guardian or youth over 18 years of age Date

THERAPY FEES

Services	Licensed Mental Health Professional
Intake (45-50 min)	$100
Individual, couple, or family session	$100
Short session (25-30 min)	$50
School Observation & Recommendations	$100/Hr
No Show Fee	Full price of session

*Fees are as of January 1, 2019 and are adjusted periodically

No Show Fee: A cancelled appointment delays our work. When you must cancel, please give me at least 24 hours notice. I am rarely able to fill a cancelled session unless I know at least 24 hours in advance. In you are unable to provide at least 24 hours notice when you cancel, you will be charged the full fee for your session unless I am able to fill it with another client. The only time I will waive this fee is in the event of serious or contagious illness or emergency.

FINANCIAL AGREEMENT

By signing below I agree to the above fee schedule and understand payment (cash or check) is due in full at the beginning of each counseling session.

I understand the following regarding use of insurance:

If I have insurance coverage, Parkwood Counseling Center is considered Out of Network. I can

- Bill my insurance using an approved diagnostic code (in which case I would be responsible for the difference between what my insurance covers and the full amount listed above)
- Decide not to use my insurance and pay in cash to the full amount listed above

If I do not have insurance coverage I will pay the fee listed above in full.

Client: _____ Date: _____

Parent/guardian: _____ Date: _____

Clinician: _____ Date: _____