Intake Information for a Minor

The following information will be kept confidential by your counselor.

GENERAL INFORMATION

Child's Name _____ Age _____ Gender _____
Address _____
Home Telephone _____ Other # _____
Emergency Contact Person _____ Phone # _____
Place of Employment _____ # of hours per week _____

PRESENTING PROBLEM

Briefly describe your child's current difficulties: _____
_____
_____

How long has this problem been of concern to you? _____
When was the problem first noticed? _____
What seems to help the problem? _____
_____
What seems to make the problem worse? _____
_____
Has the child received evaluation or treatment for the current problem in the past? Yes _____ No _____
If yes, when and with whom? _____
What do you hope/expect to get from this counseling experience? _____
_____
_____

HEALTH INFORMATION

Please rate your child's physical health: Very good _____ Good _____ Average _____ Declining ___
Recent weight changes: Lost _____ Gained _____
List important present or past illnesses or injuries: _____
_____
Physician's name: _____ Date of last exam? _____
Is the child on any medication at this time? Yes _____ No _____
If yes, please note kind of medication: _____
For what reason is your child taking the medication? _____
Has your child been treated by a psychiatrist? _____ When? _____ For how long? _____
Name of psychiatrist, if applicable: _____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

Check Disciplinary technique
_____Ignore problem behavior
_____Scold child
_____Spank child
_____Threaten child
_____Reason with child

Check Disciplinary technique
_____Tell child to sit on chair
_____Send child to his or her room
_____Take away some activity or food
_____Don't use any technique

_____ Other technique (describe) _____

Which disciplinary techniques are usually effective? _____

Which disciplinary techniques are usually ineffective? _____

What have you found to be most satisfactory ways of helping your child? _____

What are your child's assets or strengths? _____

If there is other information that you think may help us in working with your child?_____

SPIRITUAL INFORMATION

Currently attend/member of a church? _____ Which one? _____

How long? _____ Times per month attending _____

Religious background of family? _____ Does family attend with child? ____

Other religious background? _____

Are you (child) a Christian? _____ How long? _____

For child (ages 11 and up): On a scale of 1-10, (ten being highest) rate your present relationship:

_____with God _____ with prayer _____ with Bible study

For Parent: On a scale of 1-10, (ten being highest) rate your present relationship:

_____with God _____ with prayer _____ with Bible study

EMOTIONAL INFORMATION

Have you ever had a severe emotional upset?_____ Explain:_____

Have you ever had counseling in the past? _____ If yes, list counselor or therapist and dates:

What was the outcome? _____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the immediate family has had. When you check an item, please note the member's relationship to the child.

(√)	Condition	Relationship to child	(√)	Condition	Relationship to child
_____	Alcoholism	_____	_____	Heart trouble	_____
_____	Cancer	_____	_____	Depression	_____
_____	Diabetes	_____	_____	Suicide attempt	_____
_____	Other	_____	_____	Nervous or psychological Problem	_____

EDUCATION INFORMATION

Current School: _____ Phone #:_____

Teacher: _____ Grade:_____

Is your child receiving special education services? Yes _____ No _____

If yes, what type of services? _____

Has your child been held back in a grade? Yes _____ No _____

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? Yes _____ No _____

If yes, please describe: _____

Place a check (√) next to any educational problem that you child currently exhibits.

_____ Has difficulty with reading
_____ Has difficulty with arithmetic
_____ Has difficulty with spelling
_____ Has difficulty with writing
_____ Has difficulty with other subjects (please list) _____

_____ Does not like school
_____ Skips school / classes
_____ Has received detentions in this past year
_____ Has been suspended or expelled this past year

OTHER INFORMATION

What are your child's favorite activities?

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

What activities would your child like to engage in more often that he/she does at present?

1. _____ 2. _____ 3. _____

What activities does your child like least?

1. _____ 2. _____ 3. _____

Has your child ever been in trouble with the law? Yes _____ No _____

If so, please describe briefly _____

Circle the following word(s) which best describe your child now:

active ambitious self-confident persistent nervous hardworking impatient impulsive moody

often blue excitable imaginative calm serious easy-going shy good-natured introvert extravert

likeable leader quiet submissive self-conscious lonely sensitive depressed

other: _____

Does your child see or hear things that don't exist? _____

Does your child have problems sleeping? _____

Has your child talked about or attempted suicide? _____ If yes, explain: _____

_____

CURRENT FAMILY INFORMATION

Mother's name: _____ Occupation: _____
Current address: _____
Age: _____ Education: _____

Father's name: _____ Occupation: _____
Current address: _____
Age: _____ Education: _____

Step-mother's name: _____ Occupation: _____
Current address: _____
Age: _____ Education: _____

Step-father's name: _____ Occupation: _____
Current address: _____
Age: _____ Education: _____

List all others currently living in the household:

Name	Relationship to Child	Age

If any brothers or sisters are living outside the home, list their names and ages:

_____

_____

Thank You!

Child/Adolescent Psychiatry Screen (CAPS) Page: 1

Child's Name:_____ Date of Birth :_____ Male _____Female _____

Form Completed By:_____ Relationship to Child:_____

For each item below, check the one category that best describes your child ***during the past 6 months.***
None = the child never or very rarely exhibits this behavior. **Mild** = the child exhibits this behavior approximately once per week, and few others notice or complain about this behavior. **Moderate** = the child exhibits this behavior at least three times per week, and others notice or comment on this behavior. **Severe** = the child exhibits this behavior almost daily, and multiple others complain about this behavior. ***Past*** = the child used to have significant problems with this behavior, ***but not during the past 6 months.***

	None	Mild	Moderate	Severe	Past
1. Has difficulty separating from parents* (* = or major caregiver/guardian)					
2. Worries excessively about losing or harm occurring to parents*					
3. Worries about being separated from parent* (getting lost or kidnapped)					
4. Resists going to school or elsewhere because of fears of separation					
5. Resists being alone or without parents*					
6. Has difficulty going to sleep without parent nearby					
7. Physical complaints (headache, stomach ache, nausea) when anticipating separation					
8. Has discrete periods of intense fear that peak within 10 minutes					
9. Has excessive, unreasonable fear of a specific object or situation					
10. Has recurrent thoughts that cause marked distress (e.g., fears germs)					
11. Driven to perform repetitive behaviors (e.g., handwashing, doing things 3 times)					
12. Has recurrent, distressing recollections of past difficult or painful events					
13. Worries excessively about multiple things (e.g., school, family, health, etc.)					
14. Goes to the bathroom at inappropriate times or places					
15. Makes noises, and is often unaware of them					
16. Makes repetitive, sudden, nonrhythmic movements					
17. Fails to pay close attention to details or makes careless mistakes					
18. Has difficulty sustaining attention during play or school activities					
19. Does not seem to listen when spoken to directly					
20. Does not follow through on instructions; fails to finish schoolwork/chores					
21. Has difficulty organizing tasks and activities					
22. Loses things necessary for tasks are activities (toys, pencils, etc.)					
23. Is easily distracted easily by irrelevant stimuli					
24. Is forgetful in daily activities					
25. Is fidgety or squirms in seat					
26. Has difficulty remaining seated					
27. Runs or climbs excessively; is restless					
28. Talks excessively					
29. Blurts out answers before questions have been completed					
30. Has difficulty waiting turn					
31. Interrupts or intrude on others					
32. Episodes of unusually elevated or irritable mood					
33. During this episode, grandiosity or markedly inflated self-esteem (Superhero)					
34. During this episode, is more talkative than usual/seems pressured to keep talking					
35. During this episode, races from thought to thought					
36. During this episode, is very distractible					
37. During this episode, excessively involved in things (too religious, hypersexual)					
38. During this episode, dangerous involvement in pleasurable activity (spending, sex)					
39. Depressed or irritable mood most of the day, most days for at least 1 week					
40. Loss of interest in previously enjoyable activities					
41. Notable change in appetite (not when dieting or trying to gain weight)					
42. Difficulty falling or staying asleep, or sleeping excessively through the day					
43. Others notice child is sluggish or agitated most of the time					

	None	Mild	Moderate	Severe	Past
44. Loss of energy nearly every day					
45. Feelings of worthlessness or inappropriate guilt nearly every day					
46. Thinks about dying or wouldn't care if died					
47. Smokes cigarettes, drinks alcohol, OR abuses drugs (Circle all that apply)					
48. Has bad things happen when under the influence of substances					
49. Has made unsuccessful efforts to stop using a substance					
50. Is excessively worried about gaining weight, even though underweight					
51. If female, has stopped having menstrual cycles (after regularly having)					
52. Thinks he/she is fat, even though not overweight (pulls skin and claims is fat, etc.)					
53. Engages in binging and purging (eats excessively, then vomits or uses laxatives)					
54. Bullies, threatens, or intimidates others					
55. Initiates physical fights					
56. Uses weapons that could harm others					
57. Has been physically cruel to animals					
58. Has shoplifted or stolen items					
59. Has deliberately set fires					
60. Has deliberately destroyed others' property					
61. Lies to obtain goods or to avoid obligations					
62. Stays out at night despite parental prohibitions					
63. Has run away from home overnight on at least two occasions					
64. Is truant from school					
65. Loses temper					
66. Actively defies or refuses to comply with adult rules					
67. Deliberately annoys others					
68. Blames others for his/her mistakes or misbehavior					
69. Easily annoyed by others					
70. Is spiteful or vindictive					
71. Has unusual thoughts that others cannot understand or believe					
72. Hears voices speaking to him/her that others don't hear					
73. Does poorly at sports or games requiring physical coordination skills					
74. Has difficulty at school with: reading, writing, math, spelling (Circle all that apply)					
75. Had delayed speech or has limited language now					
76. Avoids eye contact during conversations					
77. Does not follow when others point to objects					
78. Shows little interest in others; emotionally out of sync with others					
79. Difficulty starting, stopping conversation; continues talking after others lose interest					
80. Uses unusual phrases, possibly over and over (speaks Disney or movie lines)					
81. Does not engage in make-believe play; plays more alone than with others					
82. Unusual preoccupations with objects or unusual routines (lines up 100's of cars, etc.)					
83. Difficulty with transitions; may be inflexible about adhering to routines or rules					
84. Shows unusual physical mannerisms (hand-flapping, shrieks, objects in mouth, etc.)					
85. Unusual preoccupations (schedules, own alphabet, weather reports, etc.)					

Thank you for answering each of these items. Please list any other symptoms that concern you:

_____

_____

_____

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

CONNECTIONS COUNSELING, LLC
900 Corbitt Drive
Wilmore, KY 40390
859-509-8468 o 859-806-9813

Request and Authorization for the Release of Information

Patient Information

Name:_____ Birth Date:_____

Social Security Number:_____

I, _____, authorize Connections Counseling, LLC. to: ☐ Receive from ☐ Disclose to

_____
Name of Agency or Facility

_____ _____
Street Address City/State/Zip

The following specific information will be received/disclosed from the above named patient's record:

☐ Evaluation/Assessment ☐ Progress Notes ☐ Discharge Summary

☐ Treatment/Service ☐ Other:_____

Date(s) of treatment:_____

I understand that the purpose of this disclosure is for:

☐ Use in treatment ☐ Other:_____

I hereby release the above named agency from all liability that may arise from the release of information requested. I expect that the information will be handled in a confidential manner.

Time Limitation: This authorization expires one year from the date of signature of the parent and/or guardian or client. This release is subject to revocation at any time.

PROHIBITION ON REDISCLOSURE: According to 45 CFR 164.508 c2Ciii health information may be redisclosed by the recipient. However, pursuant to **KRS 304.17A-555, *Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure*** mental health/chemical dependency info may not be used and/or shared by the recipient of said information unless specific, written consent for redisclosure is authorized by the person to whom it pertains. Additionally, **Federal Regulations 42 CFR, Part 2** prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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

_____ _____ _____
Client/Parent/Guardian Signature Relationship to Patient Date

_____ _____
Witness Date

Please send via mail: **Connections Counseling, LLC**
900 Corbitt Drive
Wilmore, KY 40390

Connections Counseling, LLC
900 Corbitt Drive
Wilmore, KY 40390

Alex Clark, M.A., M.Div., LMFT #169304 – 859-806-9813
Rhealynn Clark, M.A., LPCC #102212 – 859-509-8468

Informed Consent

1. **Counseling Approach**
   We use a variety of interventions to assist you. Depending on your needs, we may use Cognitive Behavioral Therapy, various Trauma and Attachment Therapy Modalities, Play Therapy, PCIT, TheraPlay, Sand Tray Therapy and/or Emotion Focused Therapy, or other therapies as needed. Your care may also include elements of Christian faith as appropriate.

2. **Goals**
   Specific goals will be developed and mutually agreed upon. The goals may be specific (change in behavior, improved relationships), or more general (less anxiety, better self-esteem). The length of therapy depends on the complexity/severity of your problems.

3. **Fees**
   Fees are on a sliding scale basis, and are due via cash, check, debit card, or credit card at the time of the session. HSA/FSA payments are also available. We do not bill insurance, but at your request, we can provide you a receipt that you can use to file your own claims. We cannot guarantee that an insurance company will reimburse you for services. A $40 fee will be charged for checks that are returned for insufficient funds. Services thereafter will be on a cash or debit/credit card only basis. Your fee for services will be based on a sliding scale according to your family's gross yearly income. Yearly income includes income such as child support payments, maintenance (alimony), and disability payments. Sessions are billed on an hourly rate for the first scheduled hour, and in fifteen-minute increments thereafter. Most sessions will last one hour, but there may also be times where Rhealynn or Alex can decide to provide additional time to complete the therapeutic work in session that day. At Rhealynn or Alex's discretion, sessions can be scheduled on Saturdays with an increased fee.

Please check on the line below to determine the hourly fee for services:

	Yearly Gross Income	Hourly Fee
_____	$0 thru $39,999	$ 65.00
_____	$40,000 thru $49,999	$ 75.00
_____	$50,000 thru $59,999	$ 85.00
_____	$60,000 thru $69,999	$ 95.00
_____	$70,000 thru $79,999	$105.00
_____	$80,000 thru $89,999	$115.00
_____	$90,000 and above	$125.00

4. **Sessions**
   Sessions will begin and end on time. If you arrive late for a session, your session time will be shortened and your normal fee will be expected. Please call 24 hours in advance if you need to change or cancel your appointment. Your appointment time has been reserved just for you. If you do not provide a 24-hour notice, you will be asked to pay for the missed session at the beginning of your next appointment. There will be a fee for a missed session.

5. **Benefits and Risks of Therapy for Minor Children**
   Therapy can be beneficial to your child in a variety of ways. Your child will receive emotional support, learn to understand feelings and problems, and be encouraged to try out new solutions to old problems. While therapy may provide significant benefits, it may also pose risks. Occasionally, a disagreement between parents and/or a disagreement between parents and counselor regarding the best interests of the child may occur. We can usually resolve such disagreements or agree to disagree, so long as this enables your child's therapeutic process. Therapy may also elicit uncomfortable thoughts, feelings, or memories.

6. **Confidentiality for Minor Children**

Therapy is most effective when a trusting relationship exists between the counselor and the child. Privacy is important in securing and maintaining that trust. Specific details of the information children share with their therapist in sessions can be shared with parents, but parents using that information in a negative interaction with the child can impar the child's trust in the safety of the therapeutic space. We will encourage children to be honest and forthcoming and to maintain an emotionally safe environment.

There are specific exceptions to confidentiality which include, but are not limited to:

- When there is risk of imminent danger to your child, we are required by law to take necessary steps to attempt to prevent such danger.
- When there is suspicion that a child is being abused or is at risk of abuse, we are mandated to take steps to protect individuals by informing the proper authorities.
- If there is known danger to another person, we are required by law to inform law enforcement.
- When we are ordered by a judge to disclose information, even after asserting professional privilege.
- You sign a release of information and authorize us to talk to someone else.
- You file a complaint or lawsuit, and while defending ourselves, Rhealynn, Alex, or Connections Counseling as an agency may disclose personal information.

7. **Children and Legal Proceedings**

It is our policy not to testify in court custody/divorce hearings. If you are bringing your child for help during this stressful time in your family's life, then the therapist's work is directed toward helping your child in therapy. Participating in court proceedings is often counterproductive to your child's therapy process. By setting this policy at the beginning of therapy, the therapy room is kept as a safe place for your child to work through emotions. In some cases, at our discretion, we may agree to write a report about your child's progress in therapy. By signing this informed consent, I/we agree not to subpoena or ask for copies of my child's records for legal proceedings, or ask for court testimony/evaluations from Rhealynn Clark, Alex Clark, or Connections Counseling as an agency. I/we also agree to instruct our attorneys not to subpoena Rhealynn, Alex, or Connections Counseling as an agency or refer to Rhealynn, Alex, or Connections Counseling as an agency in a court filing. In the event that we are asked to appear in court or provide a deposition, there will be a fee of $200.00 per hour which includes travel time to and from the location requested.

8. **Benefits and Risks of Therapy for Adults**

Counseling may involve discussing relational, spiritual, psychological, and/or emotional issues that may be distressing. There is no guarantee of outcomes as a result of participating in upcoming sessions. At any point during the counseling process, we may deem it in your best interests to be referred to another professional. If you are involved in violence, substance abuse, or have threatening behavior, we may discontinue your therapy and give you an appropriate referral. You have the right to discontinue counseling at any time.

9. **Confidentiality for Adults**

The therapist will keep everything you say completely confidential, with the following exceptions:

- You sign a release of information and authorize us to talk to someone else.
- We determine that you are a danger to yourself or to others.
- You report information about the abuse of a child, elderly person, or a disabled individual who may require protection.
- You report information regarding someone else being in imminent danger.
- When we are ordered by a judge to disclose information even after asserting professional privilege.
- You file a complaint or lawsuit, and while defending themselves, Rhealynn, Alex, or Connections Counseling as an agency may disclose personal information.
- In couple and family guidance, we do not view confidentiality as applying between a couple and/or family members and will use clinical judgment regarding sharing information.

We will not reveal your identity as a client to others. Therefore, we will not address you first if we meet you somewhere in public. We will decline any social invitations, as once we engage in our role as your counselor, we will always remain in that role in order to best preserve confidentiality. These guidelines are not meant to be discourteous in any way. They are meant for your long-term protection.

10. **Telehealth**
    Prior to providing telehealth services, adult clients or parent/guardian(s) of a minor shall be required to produce a valid photo identification. Also, an initial assessment will be completed to determine if telehealth is an appropriate delivery of treatment. Telehealth may not be appropriate if there are, or likely to be, recurrent crises or emergencies, or if there is, or likely to become, a risk of harm to self or others. Telehealth services may be terminated at our discretion if we deem it is in your best interests to be referred to another professional or in-person care. You have the right to discontinue telehealth services at any time. Telehealth services will be synchronous and conducted via a HIPAA compliant platform with built in information encryption and security. In case of technological difficulties, the therapist will call the client to arrange alternate methods of delivery.

11. **Emergency Care**
    If you have an emergency, please call 911 or go to your local emergency room. We do not provide crisis stabilization or after-hours care. You can contact us between sessions via phone or email, and we will respond at our earliest convenience. If you cannot reach us and have an emergency, please call 911 or go to your local emergency room.

12. **Child Care and Safety on the Premises**
    No provision is made for child care. If your child/children is not participating in a session, please make other arrangements for his/her care. Connections Counseling is not responsible for any accidents or injuries to children who are unsupervised by their parents on the property.

13. **Homework**
    Homework is an important part of the growth that you will make and may be given at each session attended.

14. **Documentation Requests**
    We can provide written summaries of assessments, therapeutic progress, or other reports as needed. There is a fee associated with this service. All documentation and client information is stored securely behind 2+ sets of locks.

15. **Communication and Social Media Policy**
    We do not engage with active clients via social media platforms. Communication is maintained through the therapeutic relationship while clients are participating in services with us. You can contact us between sessions via phone or email, and we will respond at our earliest convenience. If you cannot reach us and have an emergency, please call 911 or go to your local emergency room.

Please sign below that you have read, understand, and agree to comply with the above policies.

Client(s) name (printed): _____

Client(s) signature(s): _____

Parent/guardian signature(s): _____

Date: _____

Email address (for Square invoices and correspondence): _____

Phone number: _____