Child & Teen Intake Form

Client's Name (First)	MI	Last	DOB

SSN	Gender	Age	Grade

Home Phone	Child's Cell Phone

PARENT INFORMATON

Mother's Name	□ Biological Parent □ Step Parent □ Foster Parent □ Legal Guardian

DOB	Age	SSN	Marital Status □ Single □ Married □ Seperate □ Divorced □ Widowed

Does Mother Live With the Child? □ Yes □ NO	% OF Time	Address: (leave blank if same as child)

Home Phone	Cell Phone

Current Relationship With The Child: □ Positive □ Negative □ Abusive □ Absent

Father's Name	□ Biological Father □ Step Parent □ Foster Parent □ Legal Guardian

DOB	Age	SSN	Marital Status: □ Single □ Married □ Seperated □ Divorced □ Widowed

Does Father Live With The Child? □ Yes □ NO	% OF Time	Address: (leave blank if same as child)

Home Phone	Cell Phone

Current Relationship With The Child: □ Positive □ Negative □ Abusive □ Absent

Step Mother Name		Step Father Name

Home Phone	Cell Phone		Home Phone	Cell Phone

Relationship With The Child □ Positive □ Negative □ Abusive □ Absent		Relationship With The Child □ Positive □ Negative □ Abusive □ Absent

SIBLINGS

Name	Age	Relationship □ Full □ Half □ Step	Living In The Home	
Name	Age	□ Full □ Half □ Step		
Name	Age	□ Full □ Half □ Step		
Name	Age	□ Full □ Half □ Step		

SCHOOL INFORMATION

School Name	District (if applicable)	Grade

School Contact (teacher, counselor, or principal)	Phone Number

How would you describe your child's school experience?

SOCIAL AND BEHAVIORAL

How would you describe your child's social interaction (check all that apply)

◯ Spontanous ◯ Follower ◯ Leader ◯ Difficulty Making Friends ◯ Easily Makes Friends

◯ Long Term Friends ◯ Prefers To Have Only One Friend ◯ Appears Uninterested in Friends

How would you describe your child's feelings about school?

◯ Anxious ◯ Passive ◯ Enthusiastic ◯ Fearful ◯ Eager

◯ No expression ◯ Bored ◯ Rebellious ◯ Other:

How would you describe your child's approach to school work?

◯ Organzied ◯ Responsible ◯ Interested ◯ Self-directed ◯ No Initiative

◯ Refuses ◯ Does only what is expected ◯ Sloppy ◯ Disorganized

◯ Cooperative ◯ Over achiever ◯ Perfectionist ◯ Doesn't complete assignments

EMPLOYMENT

Does your child work ? □ Yes □ No If so, please answer below.

Current Employer	Position	Hours per week

LEISURE/RECREATIONAL

Describe any activities, special interes, hobbies, sports, or church activities that your child enjoys.

MEDICAL

List any current health concerns:

List any recent health or physical changes:

Please check if there have been any recent changes in the following

◯ Sleep patterns ◯ Eating Patterns ◯ Behavior ◯ Energy Level ◯ Weight

◯ General Disposition ◯ Physical Activity Level ◯ Appearance

Medications (Current Prescribed)

Medication	Dosage	Taken	Purpose	Prescribed BY

Allergic to any medications?

Substance/Chemical Use

Do you know or suspect that your child has a problem with drugs or alcoh o Alcohol o Synthetic Drugs
o Cocaine o Heroin/Opiates (pain meds) o Marijua o Excessive caffeine o Nicotine o Inhalants
o Prescription Drugs o LSD o Exctasy o other:

Is there a history of drug or alcohol use, abuse, addiction in the family? If so explain:

COUNSELING AND PRIOR TREATMENT

Provider Name	Yes	No	When	Outcome	Provider Name

Risk Assessment

Has your child ever expressed feelings of suicide? If So explain

Has your child ever attempted suicide? If so explain.

Has your child ever expressed homicidal ideations.

Has your child ever caused serious harm to someone or any animals?

Does your child see, hear, and/or feel things that others do not?

Behavioral/Emotional

- ◯ School attention/concentration problems
- ◯ Grades dropping or consistently low
- ◯ Hyperactive, difficulty being still
- ◯ Impulsive, doesn't think before acting
- ◯ Sadness or Depression
- ◯ Generalized Anxiety (across many situations)
- ◯ Specific fears/phobias (list):
- ◯ Social Anxiety
- ◯ Obsessive-Compulsive / Rigid behaviorpatterns
- ◯ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
- ◯ Isolated socially from peers
- ◯ Problems making or keeping friends
- ◯ Problems with eating
- ◯ Trouble waking up
- ◯ Problems falling asleep
- ◯ Problems sleeping through the night
- ◯ Fatigue/tiredness during the day Nightmares
- ◯ Noncompliant, purposely does not obey
- ◯ Oppositional, defiant behavior
- ◯ Problems controlling temper
- ◯ Tantrums / "Meltdowns"
- ◯ Problems with authority (breaking rules or laws)
- ◯ Physically aggressive behavior towards others
- ◯ Verbally aggressive behavior towards others
- ◯ Self-injurious / Self-harm behavior
- ◯ Wetting accidents (indicate day or night wetting):
- ◯ Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)
- ◯ History of abuse (emotional, physical, sexual)
- ◯ Alcohol or drug use/abuse
- ◯ Vocal or Motor tics
- ◯ Sensory problems
- ◯ Stress from conflict between parents
- ◯ Stress due to family financial problems
- ◯ Legal situation (anyone in family)
- ◯ Video Game Dependence
- ◯ Sexting, hyper sexual behavior
- ◯ Cell phone, soical media, internet over use

Has there been any significant changes or events in your child's life?

Any additonal information that you believe woud assist us in understanding your chid/adolescent?

Legal

Is your child under the supervision of a Deputy Juvenile Officer? If so, explain:

Is your family under the supervision of the Division of Family Services? If so who is your case worker? Name and Number

Is anyone in the family dealing with legal problems such as arrests, prisons, probation/parole? If so who?

Family History

Has any one in your child's family been diagnosed with any of the following?

	Yes	No	Who
Depression			
Anxiety			
ADD/ADHD			
Bipolar			
Schizoprenia			
Addiction			
Eating Disorder			
Personality Disorder			
Criminal Activity			

REGISTRATION FORM

Client's Full Name	DOB	Age	Gender

Address	City	State	Zip

Home Phone	Cell 1 Cell 2	Work
Is it okay to leave a message □ Yes □ No	Is it okay to leave a message □ Yes □ No	Is it okay to leave a message □ Yes □ No

Parent/Client (1) Email	Parent/Client (2) Email
Ok to discuss scheduling via email □ Yes □ No Ok to send statements or receipts via email □ Yes □ No	Ok to discuss scheduling via email □ Yes □ No Ok to send statements or receipts via email □ Yes □ No

Emergency Contact

Emergency Contact Name	Phone	Relationship to Client

Responsible Party (if minor please read minor consent form)

Responsible Party Name	Relationship to Client

Billing Address

Billing Phone Is it okay to leave a message □ Yes □ No	Email Address Ok to send statements or receipts via email □ Yes □ No

Insurance Information

Primary Insurance Company	ID Number	Group Number
Subscriber Name (who carries the insurance)	Subscriber DOB	Subscriber Employer

EAP- Employee Assistance	Insurance Co Name	Insurance Co Phone	Authorization Number	

Secondary Insurance will be billed at the discretion of each individual therapist

Secondary Insurance Company	ID Number	Group Number
Subscriber Name (who carries the insurance)	Subscriber DOB	Subscriber Employer

Copay	Coinsurance	Individual Deductible	Family Deductible	Do you have an HRA/HSA
$	$	$	$	◯ Yes ◯ No

Private Pay (As determined by you and your therapist)

Initial Session	45 min Sessions	60 minute Sessions	Family Session	Group Session

Automatic Appointment Reminders

□ Automated Phone Message Phone Number	□ Email Message Address	□ Text Message Phone Number
□ I do not wish to receive automatic reminders. **Late cancels or no shows may result in being charged your full fee.**		

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Adolescent Consent Form
&
Parent Agreement to Respect Privacy

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature	Date
Print Name	DOB

Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

◯ *I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.*

◯ *Although I know I have the legal right to request written records/session notes since my child is a minor I agree NOT to request these records in order to respect the confidentiality of my adolescents treatment.*

◯ *I understand that I will be informed about situations that could endager my child. I know this is a decision to breach confidentiality. In these circumstances it is up to the therapist's professional judgement and may sometimes be made in confidential consultation with his/her consultant or supervisior*

Parent Signature	Date
Parent Signature	Date
Therapist Signature	Date

Client Name:
DOB

River Birch Counseling Center

Minors and Shared Custody

Children with unmarried or divorced parents have ongoing developmental needs for regular contact with both parents, unless that this contact threatens the child's safety or mental health. Therapy is confidential but not secret. Parents are entitled to understand the nature of their child's probelm as well as the method and course of tretment. Only parents have access to their child's medical records. Both parents have this right of access, unless the custodial parent provides us with a court order limiting access or communication with the other parent.

In cases when the legal guardian is someone other than a parent, documentation must be provided. It is the responsiblity of the parents to notify the other parent if their child is in counseling. Our providers encourage participation of both/all parents as long as their participation does not pose a threat to the child's safety or well -being. Unless court orders or a divorce decree is presented stating other wise, the therapist may suggest or communicate with the other parent.

The role of your child's therapist is to provide psychotherapy services, not to assess fitness for custody, serve as an advocate on other issues, or act as an expert witness. However, you should be aware, if you should become involved in a legal matter and the therpist or the therapists records is subpoenaed to court, even by another party, YOU will be charged any and all applicabe fees.

The parent/guardian who registers the child for services as the client is established as the guarantorfor payment of services. When parents are divorced or have agreed to share health care expenses, it is the responsiblity of the guarantor of the account to pay the fee and to collect reimbursement from the other parent. We expect that pareents to inform the other about scheduled appointments. The late cancce or no show fee will apply if an appointment is missed regardless of which parent scheduled the appointment. The non guarantor may provide us with a copy of a credit card authorization allowing specific instructions for payment.

We are not responsible for routine communication with parents who do not attend appointments and cannot routinely contact the non custodial parent after each appointment. Expectation is that parents will communicate with each other openly regarding the treatment and that ech parent will cultivate a healthy relationshp and open communication in

Minor Agreement

I agree that the role of my child's therapist is that of a helper and will not involve him or her in legal disputes or other official proceedings unelss compelled to do so by a court of law. Matters involving court custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.

I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers not to volunteer information about the sessions, I will respect his/her right not to disclose detils. Unelss my child has been abused or is in cear danger to self or others, ther therapist will normally only tell me the following:
√ whether sessions are attended
√ wheter or not my child is generally participating
√ wheter or not progress is being made.

Client's Name		Date of Birth
Parent 1 Name	Parent 1 Signature	Date
Parent 2 Name	Parent 2 Signature	Date

Financial Policy & Office Procedures

Initial each to express your understanding.

____All copays, co-insurance, deductibles are required at the time of service.

____Each of the providers at River Birch are independent contractors. Therefore, not all take insurances, accept the same insurance, and their rates may differ.

____It is ultimately your responsibility to know your insurance coverage. If your therapist accepts insurance, we will bill insurance on your behalf. It is the discretion of each provider if they will accept secondary benefits. If your therapist is private pay we will provide a superbill at your request.

____If your insurance plan or EAP, require referrals from your primary doctor, please make sure you have that before being seen.

____At least 24 hour advance notice for appointment cancellations are required. You will be charged the full amount for the missed appointment without notice.

____In separation or divorce cases, the parent that brings the minor is financially responsible. A credit card on file is needed for any minor unattended.

____A processing fee of $25 will be charged if any check is returned.

____Any accounts that are delinquent over 120 days may be forwarded to a third party collections. 30% of your balance will be applied to cover collection cost.

Credit Card or Health Savings Card Authorization:

Credit Card Number:	
Card Holder name:	Expiration:
Zip Code	CVV (3 digits on back)
Email address or Phone number for electronic receipt:	

I have read and understand River Birch Counseling Center policies and agree to the terms.

Client Name:	Date of Birth:
Client or Guardian's Signature:	Date:

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This is acknowledgement that I have read the Notice of Privacy Practices.

I, _____, understand and agree to the terms of this office's Notice of Privacy Practice.

_____ Yes, I would like a copy for my own records.

_____ No, I do not wish to keep a copy.

Client Name _____

_____ _____

Signature / Relationship to client Date

Confidential Exchange of Information Form

Behavioral health providers and primary care physicians are required to coordinate treatment involved in a member's care. Please complete this form and we will send it to the appropriate care provider.

Client name:	Date of birth:

A. Treating Behavioral Health Provider/ Facility Information
River Birch Counseling Center **Office (636) 498-0700 Fax (636) 498-0050** **1286 Jungermann Rd. Ste. G, St. Peters, MO 63376**
Provider/Clinician Name:

B: Primary Care Physician or Other Behavioral Health Provider/Facility	
Name:	
Phone:	Fax:
Address:	

C: Patient Clinical Information

1. **The patient is being seen for the following behavioral health problem(s):**

	ADHD/Behavior D/O		Substance Abuse		Psychotic Disorder		Bipolar D/O		Depressive D/O
	Anxiety D/O		Eating Disorder		Adjustment D/O		Personality D/O		
	Other								

2. **Is the client/patient taking medication prescribed by another provider? _____Yes _____No**

3. **Coordination of care issues/other significant information impacting health care?**

_____

Date Mailed/Faxed to Clinician/Facility: _____

I hereby freely, voluntary and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in Section B. The reason is for coordination of treatment. This will last one year from date signed. I understand that I may revoke my consent at any time.

I <u>DO NOT</u> want my information shared with:

- ○ My PCP/medical provider
- ○ My other behavioral health provider

_____

Client/Guardian Signature **Date**

NOT A REQUEST FOR MEDICAL RECORDS