CHILD CLIENT INTAKE FORM

corbella
individual • couples • family • play therapy

Please list child of focus first.

Name _____ DOB _____ Age _____ Gender _____

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Biological Parent 1 - Primary		**Biological Parent 2**	
Name		Name	
Gender	Male Female	Gender	Male Female
Home Phone		Home Phone	
Cell Phone		Cell Phone	
Email Address		Email Address	
Address		Address	
Occupation		Occupation	
Employer		Employer	
		Has contact with child?	
Marital status	NEVER MARRIED MARRIED SEPARATED DIVORCED WIDOWED		

If divorced, please fill out the following	
Custody Arrangement?	
Relationship b/t biological parents	amicable hostile contentious non-existent other

Name Step-Parent		Name Step-Parent	
# of step siblings		#of step-siblings	

Please note e-mail correspondence is not considered or guaranteed to be confidential.

Where would you like me to contact you? ☐ Cell ☐ Home ☐ E-mail

Where would you like me to leave a message? ☐ Cell ☐ Home ☐ E-mail ☐ None

Emergency Contact _____ Relationship to Client _____

Cell Phone _____ Home Phone _____ Other _____

CHILD COUNSELING HISTORY

Is your child currently receiving mental health counseling services? ☐ Yes ☐ No

If yes, please describe _____

Has your child ever received mental health counseling services? ☐ Yes ☐ No

If yes, please describe _____

ABOUT YOUR CONCERNS

Has your child undergone diagnostic testing (educational, neuropsychological, etc. ?) ☐ Yes ☐ No

If yes, please describe _____

Please describe the reasons for seeking therapy for your child: _____

_____

_____

_____

_____

_____

_____

What are your goals for counseling?:_____

_____

_____

_____

_____

_____

_____

PLEASE CHECK ALL THAT APPLY

- ❑ Accident prone
- ❑ Alcohol use
- ❑ Anxious
- ❑ Argumentative
- ❑ Bites nails
- ❑ Bossy
- ❑ Breaks rules or laws
- ❑ Bullied by others
- ❑ Bullies others
- ❑ Cheats
- ❑ Class clown
- ❑ Compliant
- ❑ Complains of feeling sick
- ❑ Conflicts at school
- ❑ Conflicts at home
- ❑ Conflicts with authority
- ❑ Conflicts with friends
- ❑ Cruel to animals
- ❑ Dawdles/Wastes time
- ❑ Defiant
- ❑ Dependent or Clingy
- ❑ Depressed or Sad
- ❑ Destructive
- ❑ Developmentally delayed
- ❑ Disorganized
- ❑ Disruptive at school
- ❑ Disruptive with family
- ❑ Drug use
- ❑ Eating issues
- ❑ Failing grades
- ❑ Fearful
- ❑ Feelings easily hurt
- ❑ Fidgety
- ❑ Fighting (instigates)
- ❑ Forgetful
- ❑ Head banging
- ❑ Hits/Bites
- ❑ Hostile
- ❑ Hyperactive
- ❑ Hypochondriac
- ❑ Imaginary friends
- ❑ Immature
- ❑ Inappropriate sexual behaviors
- ❑ Inattentive
- ❑ Independent
- ❑ Inflicts pain on others
- ❑ Insults others
- ❑ Interrupts
- ❑ Intimidated by peers
- ❑ Irritable
- ❑ Lacks concern for others
- ❑ Lacks motivation
- ❑ Lacks respect/ authority
- ❑ Learning disability
- ❑ Legal difficulties
- ❑ Lethargic
- ❑ Likes to be alone
- ❑ Loss of friends
- ❑ Low frustration tolerance
- ❑ Lies/Manipulates
- ❑ Masturbates
- ❑ Moody
- ❑ Mute/Refuses to speak
- ❑ Needs excessive supervision
- ❑ Nervous
- ❑ Nightmares/Night terrors
- ❑ Noisy
- ❑
- ❑ Oppositional
- ❑ Outgoing
- ❑ Overactive
- ❑ Overly obedient
- ❑ Overly sensitive
- ❑ Picks on others
- ❑ Pouts
- ❑ Refusal/resistant
- ❑ Repetitive movements
- ❑ Restless
- ❑ Resistant
- ❑ Runs away
- ❑ Self-harming behaviors
- ❑ Sexualized behaviors
- ❑ Sexually Active
- ❑ Smokes
- ❑ Speech difficulties
- ❑ Stealing
- ❑ Stubborn
- ❑ Suicidal talk/ideation
- ❑ Swearing
- ❑ Temper tantrums
- ❑ Talks back
- ❑ Tics (movement or noise)
- ❑ Timid
- ❑ Truant
- ❑ Uncooperative
- ❑ Uncoordinated
- ❑ Unhappy
- ❑ Violent
- ❑ Wets bed/frequent accidents
- ❑ Oppositional

MENTAL STATUS AND RISK ASSESSMENT

Do you believe your child has any thoughts of harming himself/herself? ☐ Yes ☐ No

If yes, please describe _____

Do you believe your child has thoughts of harming someone else? ☐ Yes ☐ No

If yes, please describe _____

Do you believe your child has experienced emotional, verbal, physical or sexual abuse? ☐ Yes ☐ No

If yes, please describe _____

Is there a family history of substance abuse and/or mental illness? ☐ Yes ☐ No

If yes, please list relationship to child and diagnosis _____

Are there guns or weapons inside the child's home? ☐ Yes ☐ No

If yes, please describe where and how the weapons are secured _____

_____

_____

ABOUT YOUR CHILD'S HEALTH

Child's pediatrician: _____ Date of last visit: _____

Please list any concerns shared by the doctor: _____

_____

Describe any allergies your child has (food, seasonal, etc):_____

_____

HEALTH, CONTINUED

List all medications or drugs your child takes or has taken in the last year (including both prescribed and OTC):

_____

_____

Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had: _____

_____

_____

Is there a history of mental illness in the child's family, either **diagnosed** or **undiagnosed**? If yes, please explain.

_____

_____

Does any family member have a current or chronic illness? If so, please explain.

_____

_____

Please list anything else you are concerning about your child's health: _____

_____

_____

ABOUT YOUR CHILD'S FAMILY

Please list everyone living in your child's home: _____

_____

Please list anything else I should know about the child's home environment: _____

_____

Relative	Name	Age	How Well does child Get Along With This Person? 1=Poorly to 5=Very Well	Occupation
Father			1 2 3 4 5	
Mother			1 2 3 4 5	
Sister(s)			1 2 3 4 5	
Brother(s)			1 2 3 4 5	
Step Mother			1 2 3 4 5	
Step Father			1 2 3 4 5	
Step Sister(s)			1 2 3 4 5	
Step Brother(s)			1 2 3 4 5	

ABOUT YOUR CHILD'S EDUCATION

Grade	School	Average Grades	City/State
Pre-K			
K			
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

EDUCATION, CONTINUED

Current School _____Grade_____

Failure/Held Back/ Primer? _____

What do school personnel tell you about your child? _____

_____

Extracurricular Activities: _____

_____

ABOUT YOUR CHILD'S ROUTINE

What time does he/she go to bed? _____ Wake-up? _____ Average hours of sleep? _____

Does your child have any problems getting enough sleep? ☐ Yes ☐ No Wakes up frequently? ☐ Yes ☐ No

If yes, please describe _____

_____

How much caffeine does your child consume each day? ☐ None ☐ 1-3 drinks ☐ 4-6 drinks ☐ more than 6

What kinds of physical exercise does your child engage in? _____

_____

How often? _____

Is your child's diet restricted in any way? ☐ Yes ☐ No

If yes, please describe _____

Please describe any concerns you have with your child's diet/appetite: _____

_____

FINANCIAL RESPONSIBILITY

Name _____ Relationship to Client _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Cell Phone _____ Home Phone _____

Employer _____ Occupation _____

Authorization and Release: I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Corbella Counseling the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid to him for services rendered and/or for cancelled or missed appointments.

_____

signature date

AGREEMENT FOR THERAPY WITH A MINOR

I, _____ the parent /legal guardian of the minor, _____ give my permission for this minor to receive therapeutic services provided by Kaitlin Sutherlin, M.S., LPC-INTERN, NCC

- I have read, understood, and signed the informed consent related to my child's therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both this minor and his or her family.
- Furthermore, I understand that, as guardian, I am expected to participate in this process by meeting with the therapist at least once a month.
- My signature below means that I understand and agree with all of the points above.

_____

Signature of Parent/Guardian Date

PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT
Kaitlin Sutherlin, M.S., LPC-Intern
Under the Supervision of Toni Scalise, M.Ed., LPC-S, RPT-S, NCC

QUALIFICATIONS: Qualifications: I graduated with my Masters in Counseling from Southern Methodist University. I am currently working towards becoming fully licensed in the state of Texas by obtaining a required 3,000 hours in the field under the direct supervision of Toni Scalise, M.Ed., LPC-S, RPT-S, NCC. My theoretical orientation is Developmental Counseling and Therapy. Based on my education, experience and training, I am qualified to work with children, adolescents, adults, parents and groups. I have worked with clients of all ages in a variety of settings with various presenting issues.

INFORMED CONSENT:

- Both parents or legal guardians must initial next to each item and sign where requested (either on the same or separate copies of this document.) _____/_____

- I understand that Kaitlin Sutherlin, M.S. is a Licensed Professional Counselor Intern in the state of Texas, under the supervision of Toni Scalise, M.S., LPC-S, RPT-S, NCC. Therefore, sessions may be recorded and viewed by Toni Scalise for supervision purposes. Cases will be reviewed on a weekly basis. _____/_____

- I understand that Kaitlin Sutherlin does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1, or go to an emergency room for assistance. _____/_____

- I understand that during the time that we work together, we will meet weekly for approximately 50 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. _____/_____

- I understand our contact will be limited to counseling sessions and phone contact. If a phone consultation is necessary you may call Kaitlin at (214) 433-6433 xt 701. Applicable fees for phone consultation services ***exceeding 15 minutes*** will apply. _____/_____

- I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and those specific results are not guaranteed although benefits are expected from counseling. _____/_____

- I understand that counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in my life perspectives and decisions. These changes could be temporarily distressing. _____/_____

- I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with Kaitlin Sutherlin's services as a therapist, I have a right to let her know. If I do not feel that Kaitlin may resolve my complaint, I may contact her supervisor, Toni at (214) 433-6433 xt 700. I may also file a formal complaint through contact with the Texas Board of Examiners of Licensed Professional Counselors at 1(800) 942-5540. _____/_____

- I understand that our paths may cross in social situations but that our therapeutic relationship comes first. In order to protect my confidentiality Kaitlin will not initiate a greeting and will only address me if I initiate contact. _____/_____

- Should Kaitlin believe that a referral is necessary, she will provide me with said referrals. _____/_____

- Should Kaitlin's employment end at Corbella Counseling, I understand that I may be reassigned to another counselor at Corbella Counseling and Kaitlin will aid me in the transition process. _____/_____

COUPLES:

- I understand that if I am seeking services that involve another person (parent, partner, ex-partner, etc) that Kaitlin will not "keep secrets" from the other party if receiving services together. If I divulge information to her in private, she will highly encourage full disclosure with the other party involved and facilitate the process. If full disclosure is not possible, she may terminate joint counseling and only see one member of our party or refer us to another therapist. _____/_____

CONFIDENTIALITY:

- I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are ***typical, but not exhaustive***, examples of situations and circumstances under which information may be disclosed without prior consent:

    - You are a danger to self or someone else.
    - In situations of ***suspected*** child, spouse, or elder abuse, it is the legal duty of the mental health provider to notify medical, legal, or other authorities.
    - You disclose sexual contact with another mental health professional.
    - If you or your child is involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
    - Kaitlin Sutherlin is ordered by a court to disclose information.
    - You direct Kaitlin Sutherlin in writing to release your records.
    - Kaitlin is otherwise required by law to disclose information.

- I have read and understand each of the aforementioned limits to client confidentiality. _____/_____

- I understand that should an emergency occur with Kaitlin Sutherlin, Toni Scalise may contact me on Kaitlin's behalf. _____/_____

- I understand that should Kaitlin become incapacitated or deceased, her files will become the property of Toni Scalise. If Toni should become incapacitated or deceased, files will become the property of the designee in her will. Currently that designee is Sarah Balint Bravo with Park Cities Child & Family Counseling. _____/_____

FINANCIAL:

- I understand that the rate for 45-minute child therapy or 50-minute adult therapy sessions and parent consultations is $110. Rates differ for family sessions, extended time, and phone calls. Cash, checks or credit cards are acceptable forms of payment. _____/_____

- I understand that all fees for counseling are due after each session. Appointments for additional sessions cannot be made until my balance is paid in full or other payment arrangements have been made. _____/_____

- I understand that if a check is returned, a processing fee of $25 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and $25 processing fee. After a returned check, the office requires credit card or cash payment of future appointments. _____/_____

- I understand that if a returned check is not cleared up in 30 days, Toni Scalise, owner of Corbella Counseling, will file a suit with the Dallas County District Attorney's Office. _____/_____

- I understand that I am responsible for any appointments that are not canceled at least 24 hours prior to my appointment time, with the exception of an emergency. I understand that if I do not cancel my appointment 24 hours ahead of time or fail to appear for the scheduled appointment, the full session fee will be charged. _____/_____

- If a balance exists longer than 30 days and no arrangements have been made to pay the balance, the credit card on file will be charged for the remaining balance. _____/_____

COURT:

- I understand that should I subpoena Kaitlin Sutherlin as a factual case witness or involve her in court-related processes, she charges a retainer fee of $1,500, with a charge of $150 every hour she is involved in case preparation, phone calls, travel, and witness time etc. _____/_____

- I understand that if I do issue Kaitlin Sutherlin a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment. _____/_____

- I understand that my records and all of our communications become part of the clinical record. Records are the property of Corbella Counseling, PLLC. Client records are disposed of five (5) years after the client has terminated services. _____/_____

TECHNOLOGY USAGE:

- I understand that personal content sent via text or email is not secure and can potentially be compromised. _____/_____

- I understand that Kaitlin Sutherlin /Toni Scalise /Corbella Counseling will not be held liable for personal information that I choose to send via email or text should confidentiality be compromised. _____/_____

- I understand that emails and texts should only be used for scheduling or exchanging information pertaining to appointments. Kaitlin will not respond to personal content sent via email or text unless it is requested. Should I need to speak with her in-between sessions with topics other than scheduling, I will do so by phone. _____/_____

- I understand that this is a professional relationship and therefore, invitations to Facebook, Instagram, LinkedIn, or ***any other social media site*** will not be accepted. _____/_____

STATEMENT OF UNDERSTANDING;

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge.

_____

Signature of Parent/Legal Guardian Date

_____

Signature of Parent/Legal Guardian Date

_____

Signature of minor Date

HEALTH PROVIDERS STATEMENT

I have inquired to insure that the patient understood the above description of the limits on confidentiality.

_____

Health Provider's Signature Date

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students who see clients at our office. In addition, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office:

_____ _____

Client signature (parent or guardian if minor patient) Date

Consent for Use and Disclosure of Health Information:
I hereby permit and release Corbella Counseling to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client signature (parent or guardian if minor patient) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

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Credit Card Authorization Form

Name: _____ Date: _____

I authorize Corbella Counseling, PLLC to charge my credit card in the amount of:
$110 for each 45-50 minute counseling session. Your therapist will give you a quote for longer sessions.

I understand it is my responsibility to keep an updated copy of my credit card information on file. If my credit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check.

_____

Client Signature Date

Name as it appears on Card: _____

☐ Mastercard ☐ Visa Credit Card #:_____

CCV: _____ Expiration Date: _____

Billing Address: _____

_____