

~ Welcome ~

Please read and complete the forms of this packet. Please note any questions you have and discuss them with your psychologist prior to or during the first session.

Child & Adolescent Intake Packet Contents:

- 1. Demographic/Financial Responsibility Form**
- 2. Private Fee Schedule Form**
- 3. Credit Card Authorization Form**
(please complete this form, even if you plan to pay by cash or check)
- 4. Office Policies and Consent to Treatment Form**
- 5. Supervision/Consultation Disclosure Form**
- 6. Notice of Audio/Video Recording Form**
- 7. Child/Adolescent Intake Questionnaire**
(for family therapy, please complete questionnaire regarding child of most concern or you may complete one questionnaire per child)

Great Life Counseling Center

14275 Midway Rd., Ste. 260

Addison, TX 75001

Jantel Jordan, Psy.D./413-798-4522/ GREATLIFECONSULTS.COM

DEMOGRAPHIC INFORMATION

Today's Date ___ / ___ / ___

Name of Child/Adolescent: _____ Date of Birth: ___/___/___

School: _____ Grade: _____

Name of Custodian Filling Out This Form: _____

Custodian Status (Joint, Sole, or Primary): _____

Relationship to the child: _____

I authorize text messages to my cell phone and messages to my contact numbers and email YES NO

(If applicable) Other Custodian Name & Status: _____

If your adolescent is old enough to drive himself/herself to therapy appointments, please provide your adolescent's email address and cell phone number so that he/she can receive appointment reminders.

Cell phone: (____) _____

Email Address: _____

Child's Primary Residence: _____ City: _____ Zip: _____

Caregiver (s) at this address: _____

If applicable:

Child's Secondary Residence _____ City: _____ Zip: _____

Caregiver (s) at this address: _____

Family Relations

Parents Status: Married Divorced Separated Never Married Widowed

Parental Rights Terminated Joint Legal Custody Sole Legal Custody

Other (Explain) _____

If divorced, what is the custody agreement (please attach copy of agreement)? _____

Mother: _____

Father: _____

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Biological • Adoptive •

Biological • Adoptive •

Date of Birth: _____ Date of Birth: _____

Ethnicity: _____ Ethnicity: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Home phone: (____) _____ Home phone: (____) _____

Cell phone: (____) _____ Cell phone: (____) _____

Email Address: _____ Email Address: _____

Emergency Contact: _____ Address _____

Relationship to child: _____ Best contact number: _____

Other Caregivers (If applicable to treatment)

Please check relationship:

- Stepfather Foster Father Legal Custodian Grandparent
- Stepmother Foster Mother Babysitter Other: _____

Name: _____ Name: _____

Date of Birth: _____ Date of Birth: _____

Ethnicity: _____ Ethnicity: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Home phone: (____) _____ Home phone: (____) _____

Cell phone: (____) _____ Cell phone: (____) _____

Email Address: _____ Email Address: _____

| Siblings | Age | Relationship |
|----------|-----|--|
| | | <input type="checkbox"/> full <input type="checkbox"/> half sib paternal <input type="checkbox"/> step sib paternal <input type="checkbox"/> step sib maternal <input type="checkbox"/> half sib maternal <input type="checkbox"/> adoptive sib |

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| | | |
|--|--|--|
| | | <input type="checkbox"/> full <input type="checkbox"/> half sib paternal <input type="checkbox"/> step sib paternal <input type="checkbox"/> step sib maternal <input type="checkbox"/> half sib maternal <input type="checkbox"/> adoptive sib |
| | | <input type="checkbox"/> full <input type="checkbox"/> half sib paternal <input type="checkbox"/> step sib paternal <input type="checkbox"/> step sib maternal <input type="checkbox"/> half sib maternal <input type="checkbox"/> adoptive sib |
| | | <input type="checkbox"/> full <input type="checkbox"/> half sib paternal <input type="checkbox"/> step sib paternal <input type="checkbox"/> step sib maternal <input type="checkbox"/> half sib maternal <input type="checkbox"/> adoptive sib |
| | | <input type="checkbox"/> full <input type="checkbox"/> half sib paternal <input type="checkbox"/> step sib paternal <input type="checkbox"/> step sib maternal <input type="checkbox"/> half sib maternal <input type="checkbox"/> adoptive sib |

Please list any other people living in the home: _____

Other Health Care Providers

Pediatrician:

Name: _____

Phone: _____

Psychiatrist (if applicable):

Name: _____

Phone: _____

Who referred you to Great Life Counseling Center? (Please circle one):

Internet Search

Insurance Co.

Friend

Physician

Other: _____

If referred by an individual, do you give permission to acknowledge the referral? YES NO

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**INSURANCE INFORMATION AND
CONSENT TO FINANCIAL RESPONSIBILITY**

Insurance information

Name of Insured (Policy holder): _____ Date of Birth of Insured: ____/____/____

Insurance Carrier: _____ Insurance Phone#: _____ Co-pay \$ _____

Deductible: _____ Deductible Met: _____ Pays at: _____

Policy/ ID#: _____ Group#: _____ Employer: _____

FINANCIAL RESPONSIBILITY

- Great Life Counseling Center clinicians are currently out-of-network providers for all insurance companies, except Blue Cross Blue Shield PPO.
- If you (the parent/guardian responsible for this minor) would like to pay through BCBS, please inform your Great Life Counseling Center clinician and contact your representative to verify the minor’s behavioral healthcare coverage prior to the initial appointment.
- Great Life Counseling Center will electronically submit claims to BCBS. BCBS will be billed for the contracted service fee minus your copayment or your full payment of the contracted service fee. If you owe a deductible, each full payment claim will be credited toward your deductible. Great Life Counseling Center may be required to release treatment information about your care to your insurance provider including, but is not limited to, diagnosis codes, dates of service, treatment plans, and treatment progress.
- Private payment of services, copays, and administration fees are due in full at the time of each appointment. Walkout statements for out of network claims can be downloaded through the profile you created with our electronic health records system-TherapyAppointment.com.
- ❖ If Blue Cross Blue Shield PPO should deny payment or reimbursement for any reason, you remain ultimately responsible for any outstanding financial debt associated with services provided, including no show/late cancellation fees (which are not covered by insurance). Great Life Counseling Center reserves the right to charge your credit card on file or other credit cards used for prior payments; email or mail an invoice, and/or utilize a collection agency in efforts to address outstanding balances. You are also responsible for making sure Great Life Counseling Center has updated contact & billing information.

Please Acknowledge the Above Statements with Initials _____

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PAYMENT OF FEES:

- ❖ Payment is due at the time services are rendered in the form of **cash, check, or charge**. All checks should be made out to **Great Life Counseling Center**. MasterCard, Visa, American Express, & Discover are accepted but cash & check payments are preferred.
- ❖ For insurance reimbursements or more detailed receipts, clients may request a walkout statement to be given in paper form or sent to an email address.
- ❖ Clients will be given the option to add no show or late cancellation charges to the cost of the next session as long as the next session is scheduled to occur within 10 days of the cancellation. Clients are also welcome to mail a check but are advised to mail it at least 4 days prior to the 10 day deadline. Please note: no show/late cancellation fees are not usually reimbursed by insurance companies.

SUMMARY OF FEES

Direct Contact Fees (may be covered by insurance):

Child/Family Therapy Sessions (with client present)

CPT Code 90837 (55-60 min).....\$130/hour

.....Play/Art Therapy surcharge (per 55 minutes) = \$20

.....Weekend session surcharge (per 55 minutes) = \$20

.....Additional time pro-rated by 15 minute increments

Guardian or Family Member Consultation (without client)

CPT Code 90846 (55-60 min).....more than 15 min. - \$130/hour (pro-rated)

Phone & E-Consultation fees15 min. or less - FREE; 15+ min. - \$130/hour (pro-rated)

Consultation with Other Professionals (with written consent).....more than 15 min. - \$130/hour (pro-rated)

(i.e., teachers, school psychologist, psychiatrist, doctor, etc.)

Indirect contact/Administration fees (not covered by insurance)

Other services (i.e. write letters, fill out forms, report writing).....\$130/hour (pro-rated)

Legal (i.e., attorney calls, reports, testimony preparation & court appearances).....\$300/hour (pro-rated)

.....(4 hour minimum/retainer = \$1200)

Preparation of Record Summary Letters.....\$130/hour (pro-rated)

Returned/Invalid Check Fee.....\$50.00

Late Cancellation Fees (less than 24 hours of notice).....50% of session fee

No show Fees (notice not provided prior to scheduled appointment time).....100% of session fee

- If a Great Life clinician has authorized a session rate modification/discount/coupon, please note on line below & confirm agreement during initial appointment.

GLCC clinician initial _____

With my signature below, I acknowledge the statements above and accept financial responsibility for services rendered. I authorize Great Life Counseling Center to bill me directly for services provided, not covered by insurance, or any administration fees not covered by insurance.

_____ Date _____

Parent/Guardian signature

_____ Date _____

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Parent/Guardian signature

A copy of this completed & signed document will be provided at your request.

Credit Card Authorization Form

****It is the policy of this office to keep a debit/credit card on file. You may pay by cash or check, but a card must still be kept on file.****

This policy exists both for your convenience as well as a way to insure that outstanding balances are paid in a timely manner. You will be notified via phone/voicemail, text, and/or email prior to any charges being applied to your card.

With my signature, I authorize Great Life Counseling Center to charge my credit/debit card & imitate my signature for the e-sign authorization for the following outstanding charges:

- All visits for which payment was not made at time of visit (this includes fees for service, deductibles, and co-pays).
- 50% of the session fee for each late cancellation (less than 24 hours of notice)
- 100% of the session fee for each no show

Client/Card Holder Signature

Date

Name _____
Print Last First Middle Initial

Name on Card (if different)

Type of Card: Visa MasterCard Discover American Express

Credit Card Number _____ - _____ - _____ - _____ CVV Number _____ 3-digit number on **back** of card or
4-digit number on **front** of AE card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements:

Street Address Apt./Ste./Room #

City State Zip

Card Holder Signature _____, Date ____ / ____ / ____

Email address and/or phone number for receipts _____

A copy of this completed & signed document will be provided at your request.

Office Policies and Informed Consent

Great Life Counseling Center

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For Child & Family Therapy Treatment

Office Policies and Informed Consent

Welcome and thank you for entrusting Great Life Counseling Center (GLCC) with your care! This document contains important information about our professional services, business practices, and it will serve as a therapeutic contract. Please read it carefully and jot down any questions you would like to discuss.

Philosophy/Approach

Individual Child Therapy Sessions (sessions with a minor)

- ❖ Most young children do not respond well to talk therapy. Play & art therapy are often utilized to build, develop, & maintain rapport as well as examine your child's worldview. The number of sessions needed to establish rapport & understand your child well enough to make significant interventions may vary from 1 to 3 sessions or more, depending on the child's openness & comfort with the therapy process as well as their overall ability to share their experience. However, you can be assured that your clinician will work hard to put your child at ease.

Child Therapy = Parent/Child or Family Therapy

- ❖ An important part of child therapy includes regular meetings with parents or parents & children together. Both parent and family meetings are an essential part of your child's growth in therapy as well as an important factor for increasing the likelihood of gains being further developed & maintained beyond treatment.
- ❖ At the onset of treatment, all legal guardians and other primary caretakers are strongly encouraged to be involved and attend at least one of the first 3 sessions. This is not always feasible but strongly preferred.
- ❖ Consistent weekly attendance to sessions and follow through on recommendations are vital factors for successful treatment outcomes.

Family Therapy (at least 1 legal guardian & 1 minor)

- ❖ All family members affected by or contributing to the issues of concern will be encouraged to provide input at some point, if not regularly.
- ❖ Family sessions give the parents and child an opportunity to work on new skills or ways of relating with the psychologist's support & guidance.

About the Therapy Process

- ❖ Child & family counseling has some inherent risks and many potential benefits.

Risks

- Possible risks for therapy include the possibility of disagreement between parents or between parents & psychologist regarding conceptualization of the problem, determining what needs to change, or how change needs to be achieved. Other risks include the treatment being ineffective, changes not meeting your expectations, and relapse & regression. If any of these negative results or issues occurs, your psychologist will make every effort to listen, understand, and respond to your concerns.

Benefits

- Although there are no guarantees about the outcomes of therapy, the benefits of therapy for children & their families often include the reduction of concerning behaviors, the enhancement of their ability to articulate their feelings, improved relationships (with parents, other family members, teachers, & peers), better coping strategies, and an increase in emotional well-being.
- ❖ Trust between clients and their psychologist is vital to the therapy process, especially for young children. Child therapy is most effective when the child views it as a sanctuary in which they are completely free to express themselves. In order to create & maintain this safe environment for the

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child, the specific details of what your child discloses in individual sessions will not be shared with you (the legal guardian) or anyone else without the child's verbal consent, unless there is a concern for the child's safety or the safety of others. However, your psychologist will inform your child that general themes, treatment plans, & progress updates are shared with guardians. The child will be strongly encouraged to share their experience of the session with you but interrogating the child for specific detail is discouraged.

- ❖ *In the process of child therapy treatment, conflicts between parents & differences in parenting styles or philosophies become relevant to the child & family's treatment. However, it is important that the focus of these discussions maintain a strict focus on discovering a resolution that will best benefit your child (or children). This means that both guardians agree not to utilize the child's treatment or psychologist's session comments to gain an advantage in any legal proceedings. You also agree that you will avoid involving your psychologist in any legal processes that would require the psychologist to take sides with one of the child's guardians or share details about your child's sessions. You must also agree to instruct your attorneys to not subpoena records or refer to anything your psychologist has said in any court filing without your psychologist's consent.*
- ❖ Marriage & couples therapy are not considered the same as family therapy. Couples therapy issues are treated separately and require completion of a separate intake packet. If parents are in need of this treatment, separate treatment for these issues can be arranged with a separate GLCC clinician or a referral to other experienced & qualified clinicians in the area.

Custody/Guardianship

- ❖ Consent for services can only be authorized by a current legal guardian.
- ❖ For divorced parents, consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required.
 - Please Note: A copy of the divorce decree must be included in the client file indicating the custodial arrangement.
- ❖ Permission from both parents, regardless of the custodial arrangement is the preferred practice of this office.

TERMINATION OF THERAPY PROCESS

Ideally, the therapy sessions will end when psychologist & client/family mutually agree treatment goals have been adequately met. However, there are times when therapy sessions need to be discontinued for a time or spaced out due to financial reasons, conflicts in schedule, physical illness, or relocation. The psychologist may also decide that client would be better served by another clinician and refer client to a colleague.

Regardless of reasons for termination, continuity of care is vital to effective treatment and clarity regarding the status of the therapeutic relationship is a necessity for accurate record keeping. Thus, it is preferred that clients and/or guardians inform their psychologist of their intention to terminate sessions at least one session in advance. When this is not feasible, clients are asked to at least inform their psychologist of plans to discontinue or take a break from sessions as soon possible.

Unless a date & time has been established for the next session, termination of the therapy relationship will be assumed after 2 weeks of no correspondence or booking of the next appointment. At such time, clients may be sent an email informing them of this default termination & requesting that all outstanding balances are paid within 1 week of their last session. Clients/Families that have terminated therapy are always welcome to return to treatment as long as outstanding balances have been resolved.

OUTSIDE-OF-SESSION COMMUNICATION & EMERGENCY PROCEDURES/POLICIES:

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- ❖ Telephone, text, & email consultations between office visits are welcome. However, any contact outside of session will be kept brief. Clients and their legal guardians are encouraged to consider scheduling additional sessions or waiting until their next session to discuss matters that will take more than 15 minutes to explore. If out-of-session correspondence requires more than 15 minutes of the psychologist's time, charges for each 15 minute increment will incur (including the first 15 minutes). Payment for such consultations is due at the start of the next session or within 10 business days (whichever occurs first).
- ❖ **Clients and their legal guardians are welcome to transmit voicemail, email, or text messages to their psychologist/clinician but these communications must remain brief (i.e., not requiring more than 15 minutes of therapist's time to review & respond) or charges will incur.** On weekends and holidays, messages are checked less frequently. Calls, texts, & emails will generally be responded to within 24 hours or by the end of the next business day.
- ❖ **Great Life Counseling Center's contact number is *not* an emergency number. In the event of a mental health or medical crisis, please call 911 or one of the following crisis lines, which are available 24/7:**
 - Suicide & Crisis Center of North Dallas – **214-828-1000**
 - National Suicide Prevention Lifeline – **1-800-273-TALK**
 - National Domestic Violence Hotline – **1-800-799-SAFE**
 - National Sexual Assault Hotline – **1-800-656-HOPE**
 - If your crisis is due to a medical issue or medication, contact your physician or psychiatrist.
- ❖ **Vacation:** Clients & their guardians are informed in advance whenever their psychologist plans to be unavailable for more than 2 business days. In these events, arrangements may be made for coverage, if the psychologist determines it is necessary or it is requested by the client or client's guardian. Otherwise, clients & their guardians are encouraged to utilize one of the crisis lines listed above for assistance in the absence of their GLCC clinician.

CONFIDENTIALITY:

In most cases (see "Exceptions to Confidentiality" below) communications between client and psychologist will be held in strict confidence - unless client provides psychologist with written permission to release information about treatment or there is an imminent safety threat.

Protecting client privacy is a high priority for Great Life Counseling Center & its associates. Intake paperwork, therapy notes, consultation notes, & reports are kept in a locked file cabinet until they are typed or scanned & uploaded into an accredited web-based electronic health records system, which is currently TherapyAppointment.com. Scheduling & file information on TherapyAppointment.com is protected with bank-level security, which includes the highest levels of data infrastructure, virus prevention, spam filtering, and encryption measures. Prior to being archived on TherapyAppointment.com, encrypted records are kept on a secured flash drive so they are not saved on any computer. For additional information about your privacy rights & HIPPA, visit the HIPPA website:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html>

EXCEPTIONS TO CONFIDENTIALITY

Safety Concerns

Psychologists & other mental health professionals are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse. Psychologists are may also break client confidentiality in an attempt to prevent a client from harming themselves or others.

Professional Consultation

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In accordance with recommended best practices, Great Life Counseling Center clinicians regularly consult with each other and enjoy collaborating to provide the best care possible. These consultations may include the review of video recordings or just an exploration of different strategies for improving the likelihood of positive outcomes. However, identifying information is never shared with anyone outside of the clinical team and, after recordings or presentation materials have been reviewed by the Great Life Counseling Center team, they are immediately shredded or deleted.

Electronic Communication, Videoconferencing, or Phone

Great Life Counseling Center is nearly paperless business and relies on different information technologies such as emails, text messages, phone calls, video conferences, fax, & an electronic medical record system to communicate, record, and store client information as well as transmit business transactions. Use of these technologies allows Great Life Counseling Center to serve your needs more efficiently and effectively and Great Life Counseling Center associates take reasonable steps to protect the privacy of its clients & minimize risk of any breach or errors in transmission. However, clients are required to acknowledge and accept the inherent risks of such technologies and electronic mechanisms (e.g., risk of information being erased or destroyed due to a malfunction or act of God; information intercepted and/or hacked by unauthorized parties; or information being erroneously transmitted to the wrong email, fax number, or phone number).

ACKNOWLEDGEMENT OF POLICIES & CONSENT TO TREATMENT:

- ❖ With my signature below, I acknowledge that I have had ample opportunity to read the information in this policies & consent to treatment document. My signature also indicates that I understand & accept the stated policies, expectations for participation, fees, and risks noted herein.
- ❖ My signature also confirms that I am the legal guardian of (list full legal names of all minors who may attend sessions)_____

_____ and I consent to the treatment and participation of each child listed.

- ❖ Finally, my signature indicates my willingness to abide by all the terms of this agreement, my personal consent to fully participate in the treatment process, and my commitment to paying for all services rendered in a timely fashion.

_____ **Date** _____
Parent/Guardian signature

_____ **Date** _____
Parent/Guardian signature

A copy of this completed & signed document will be provided at your request.

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Supervisory/Consultation Disclosure Form

Jantel Jordan, Psy.D. is a Postdoctoral Fellow at Great Life Counseling Center. In order to become a Postdoctoral Fellow for Great Life Counseling Center, Dr. Jordan had to achieve her doctorate in the field of psychology along with at least 3 years of experience practicing at other clinical sites. Dr. Jordan is now eligible for provisional licensure in the state of Texas and she has begun the application process. She has been authorized by the Texas State Board of Examiners of Psychologists to practice as a trainee under the guidance of a Texas licensed psychologist in good standing.

In order to ensure the highest standard of care, Dr. Jordan and her primary supervisor will meet weekly to discuss and review Dr. Jordan’s documented work with you. The limits of confidentiality delineated in the Consent for Counseling Treatment form apply to supervision and case consultations with members of the Great Life Counseling Center clinical team. Great Life Counseling Center is able to assure the highest quality services to each client due to an emphasis on qualitative reviews, training, and clinical collaboration.

This form will become part of your clinical record and a hard copy will be provided to you upon request. If you have any questions about this form, you are welcome to consult Dr. Jordan or one of her supervisors for clarification. Signing this form acknowledges your informed consent for treatment by a clinician under supervision, including your permission for your clinician to disclose your confidential information with her supervisor and consult with other members of the Great Life Counseling Center clinical team. You will have the right to withdraw permissions for consultation disclosure at any time but it will result in the transfer of your clinical work to a licensed psychologist.

Therapist’s Name: Jantel Jordan, Ph.D.

Primary Supervisor’s Name: Nikki Stillo, Ph.D.

Secondary Supervisors’ Names: Kevin Lambert, Psy.D. and Blair Kenney, Psy.D.

_____ Date _____
Parent/Guardian signature

_____ Date _____
Parent/Guardian signature

A copy of this completed & signed document will be provided at your request.



Notice of Audio/Video Recording

Great Life Counseling Center is able to assure the highest quality services to each client due to an emphasis on qualitative reviews, training, and clinical collaboration. In order to ensure the highest standard of care and safety, Great Life Counseling Center audio/video records office activity for surveillance purposes and your Great Life Counseling Center clinician may audio/video record clinical meetings for research/training purposes. Recordings of clinical meetings may be qualitatively reviewed during supervision/consultation meetings and group case consultation meetings with members of the Great Life Counseling Center clinical team. The limits of confidentiality delineated in the Consent for Counseling Treatment form apply to supervision/consultation meetings and group consultations with members of the Great Life Counseling Center clinical team.

This form will become part of your clinical record and a hard copy will be provided to you upon request. If you have any questions about this form, you are welcome to consult your Great Life Counseling Center clinician for clarification. Your signature below indicates you give Great Life Counseling Center and your clinician permission to audio/video record and you understand the following:

1. The purpose of audio/video recordings shall be for training/research and surveillance of office premises. Your Great Life clinician may utilize samples of or complete audio/video recordings for qualitative reviews and constructive feedback from members of the Great Life Counseling Center clinical team.
2. The content of these recordings will be kept in strict confidence through encryption and a secure storage system. Furthermore, they will be deleted after they have served their purpose or 4 weeks has passed since the recording. Recordings of clinical meetings will be stored separately from the clinical record and will not be transmitted to or shared with any external entities or persons prior to deletion.
3. The use of personal recording devices (e.g., phones) to record all or parts of clinical sessions without the expressed consent of the Great Life Counseling Center clinician is strictly prohibited.
4. You may request in writing the suspension or termination of audio/video recordings of clinical meetings at any time by requesting to sign the terminate/suspend session recordings form. Office surveillance of common areas like the waiting room and hallways can not be terminated or suspended for security reasons but will be kept confidential until deleted.

Date _____
Parent/Guardian signature

Date _____
Parent/Guardian signature

A copy of this completed & signed document will be provided at your request.

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INTAKE QUESTIONNAIRE

(to be completed by parent/guardian)

CLIENT NAME: _____

PARENT/GUARDIAN COMPLETING FORM: _____

PRIMARY COMPLAINTS: What caused you to bring your child/adolescent in for therapy today?

EXPECTATIONS: What do you hope to change or accomplish as a result of therapy treatment?

HISTORY OF TREATMENT: Has your child/adolescent been in therapy before? Yes No
If yes, please note the when, name of clinician/agency, and primary issues addressed:

Reflecting on the last 6 months, please circle all that apply regarding your child's struggles:

| | |
|---|--|
| Frequently sad or depressed | Feeling restless or keyed up |
| Overwhelming worries | Restless unsatisfying sleep |
| Difficulty falling asleep or staying asleep | Muscle tension |
| Unable to concentrate | Mood Swings |
| Irritable and/or short temper | Decreased need for sleep (only need 3-4 hrs) |
| Significant change in weight | Seems more talkative than usual |
| Low energy level/fatigue | Excessive spending/shopping |
| Feeling excessive guilt or shame | Abuse of alcohol or illicit substances |
| Unable to relax | Easily distracted by unimportant things |
| Lack of appetite/increased appetite | Takes too many risks |
| Loss of interest in activities/hobbies | Troubling thoughts about the past |
| Feeling hopeless | Nightmares |
| Feeling worthless | Exaggerated startle response |
| Difficulty motivating | Too neat and orderly |
| Withdrawn/isolating self | Repeating certain behaviors over and over |
| Cry easily/often | Easily upset or angered |
| Difficulty making a decision | Feeling different from most people |
| Difficulty finishing tasks | Shy around others |
| Thoughts to hurt self | Increasingly forgetful |
| Attempts to harm self | Strong fears |
| Thoughts to hurt others | Difficulty with work or school |
| Threats to hurt others | Use of painkillers and analgesics |
| Feeling ill/sick | Stomach aches/vomiting |

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SUPPORT SYSTEMS

Please describe or elaborate

| | | |
|---|---|--|
| Does your child have one or two close friends? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you and/or your child have a religion or spiritual practice? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Does your child belong to any social groups or participate in hobbies they enjoy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Does your child have a close relationship with each parent or primary caregiver? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Does your child have hopes or dreams for their future? Are they inspired by any particular role models? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

FAMILY HISTORY

Have you or anyone in your family, experienced any of the following? If yes, please note their relationship to you. Please include extended family such as grandparents, uncles/aunts, siblings, and so on.

| Has anyone experienced: | Family Member(s) |
|---|-------------------------|
| Anxiety | |
| Depression | |
| Bipolar disorder | |
| Learning disorders (ADHD, dyslexia, etc.) | |
| Illicit drug use | |
| Alcohol abuse | |
| Schizophrenia | |
| Anger | |
| Eating Disorder | |
| Phobias | |
| Hospitalization for Mental Health Condition | |
| Attempted or completed suicide | |

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Medical History
Check if client has or had, any symptoms in the following areas to a significant degree and briefly explain.

| | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Chest/Heart | <input type="checkbox"/> Seizures | Any Recent Changes In: <input type="checkbox"/> Weight <input type="checkbox"/> Energy Level <input type="checkbox"/> Ability to Sleep <input type="checkbox"/> Mood Other Pain/Discomfort: |
| <input type="checkbox"/> Back | <input type="checkbox"/> Head/Neck injury | |
| <input type="checkbox"/> Intestinal | <input type="checkbox"/> Ear/Nose/Throat | |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Bowel | <input type="checkbox"/> Skin | |
| <input type="checkbox"/> Circulation | <input type="checkbox"/> Lungs | |

Childhood illnesses: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio
Immunizations: Tetanus Pneumonia Hepatitis Chickenpox *Influenza

Has your child ever been hospitalized for any emotional/ mental health condition? Yes No
If Yes, please provide dates/details:

| |
|--|
| |
|--|

Has your child ever been hospitalized for any surgeries/hospitalizations? Yes No
If Yes, please provide dates/details:

| |
|--|
| |
|--|

Is your child currently being treated for any medical problems? Yes No
Is your child currently taking any prescribed medications? Yes No
List medications:

| Medication | Dosage | Purpose (i.e. depression) | Prescribed by |
|------------|--------|---------------------------|---------------|
| | | | |
| | | | |
| | | | |

Is your child currently taking over the counter medications, herbs or supplements? Yes No
Would you consider your child to presently be in general good physical health? Yes No
If No, please explain _____
Does your child engage in regular physical activity? Yes No
If yes, what activities? _____ How often? _____

Has your child ever experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one, etc.*) Yes No

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| | |
|---|--|
| Does your child have a history of being violent or destructive? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has your child been verbally, emotionally or physically abused? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has your child been a victim of sexual abuse or sexual assault? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has your child been a victim of sexual abuse or sexual assault? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you answered 'Yes' to any of the questions in this box, please provide the general details below (including date/duration of events) | |
| <hr/> <hr/> <hr/> <hr/> | |

| | |
|---|--|
| Does your child have history of any legal issues: (custody litigation, CPS involvement, drug or alcohol or Juvenile Justice System)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your child have a history of psychotherapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your child have a history of Speech Therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your child have a history of Occupational? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your child have a history of psychological testing/Educational Testing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you answered 'Yes' to any of the questions in this box, please provide the general details below (including date/duration of events) | |
| <hr/> <hr/> <hr/> <hr/> | |

| | |
|--|--|
| Has your child even been diagnosed with a Learning Disability)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has your child ever received Special Education services? (If so, what type?) | Yes <input type="checkbox"/> No |
| <hr/> <hr/> <hr/> | |

Prenatal & Early Developmental History

The client is the mother's 1st born 2nd born 3rd born 4th born Other:_____

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1. Does mother have history of previous: Miscarriage Abortion Stillbirth
2. During the pregnancy, were there any complications, unusual symptoms, high emotional stress, or physical injuries? _____
3. Any use of and/or exposure to Tobacco Coffee/Caffeine Alcohol Heroin
 Marijuana Methamphetamine Cocaine Other _____
 Also, list any medication used during pregnancy:
4. Was the pregnancy full-term (40 weeks)? Yes No, born premature at ___ weeks.
5. During delivery were there any complications, unusual symptoms, or problems that occurred?
6. Delivery was: C-Section Vaginal Head First Feet First Breech Vacuum
 Birth weight: _____pounds _____ounces

Developmental Milestones

| | Age | | Age |
|--------------|-------|----------------------|-------|
| Hold Head Up | _____ | Stood Independently | _____ |
| Rolled Over | _____ | Walked Independently | _____ |
| Sat Up | _____ | First Word | _____ |
| | | Combined Words | _____ |
| | | Toilet Trained | _____ |

Any additional information of significance regarding early development.

Please note any other areas/issues of concern:

~ Thank you ~