# CHILD/TEEN INTAKE FORM

Please fill out this form and bring to your first session. All information is kept confidential.

## GENERAL INFORMATION

Today's Date: _____

Child's Name: _____

Child's Age: _____

Date Of Birth: _____

Home Address: _____

Your Name: _____

Your relationship to client: _____

Cell Phone: _____ May I leave a message? Yes No

Work Phone: _____ May I leave a message? Yes No

Email: _____ May I email you? Yes No

Name(s), of child's legal guardian(s) other than yourself: _____

His/her phone number and email: _____

Emergency Contact: _____

Relationship to child: _____

Phone number: _____

What is the main reason you are seeking counseling for your child?

What are your hopes and goals for counseling for your child?

**FAMILY HISTORY**

Are you currently: Single Married Separated Divorced Remarried Co-parenting
Describe custody arrangement if applicable:

Who lives in your home?

How many hours/week do you work?

If applicable how many hours does your spouse/partner work?

Are there step-parents? Yes No
If you are NOT the child's step-parent, please describe your impression of your child's relationship to her or his step-parents:

Did you adopt this child? If so, please share details of the adoption here:

Do you have other children? Please write their names, ages, and a brief statement about your relationship to each of them.

How would you describe your child's relationship to his/her siblings?

From your point of view, how would you describe the overall family atmosphere in your home?

If you are the birth mother, please describe your pregnancy and childbirth experience. (Please include whether you used tobacco, alcohol, or drugs while pregnant, and any significant life events or stressors that were happening while you were pregnant).

Please list any significant losses such as a death in family/significant others including pets, relocating, natural disasters, etc. Please list names and dates:

Please list any family history (yours and your spouse/partners') with alcoholism, addiction, mental illness, trauma or violence (including suicide, depression, hospitalization in a mental institution, abuse, domestic violence, trauma of natural disaster, etc):

From your point of view, please describe your relationship with your child:

Are you satisfied/dissatisfied with your relationship with your child?

Do you spend time one on one with your child? Yes No

How often and what do you do together?

Does this amount of time and quality of time feel sufficient/satisfying to you? Yes No

What do you believe are your strengths as a parent to your child?

What are the areas you'd like to improve as a parent to your child?

**PHYSICAL/MENTAL HEALTH HISTORY**

Has your child ever expressed suicidal ideations? When and how frequently?

If so, how concerned are you that your child is currently suicidal?

Has your child ever engaged in any kind of self-destructive words or behaviors? When and how frequently?

Has your child ever been prescribed medication for psychological/behavioral or emotional problems? Please list the name of medication and why it was prescribed, the type of doctor who prescribed it, and any results or conclusions that you have about this experience:

Has your child ever spent time in a hospital or outpatient/inpatient agency for psychiatric challenges? If yes, please list dates and reasons for admission:

Please list with dates, any current or past related issues that your child has had, such as major medical problems, illnesses, surgeries, accidents, traumas, etc:

To your knowledge, has your child ever been abused physically, sexually, verbally, or emotionally?
If yes, when and by whom?

If yes to the above, has your child gone to counseling for this? When and how long?

Has your child received mental health counseling before? Please include dates, reason, with whom, and how the experience was for your child:

Please list any current medications/supplements that your child is taking:

**SCHOOL, HOME, SOCIAL, AND PERSONAL FUNCTIONING**

What is the name of your child's school?
Grade?
Describe the type of student that your child is?

Are there any current school related issues either academically or otherwise?

From your point of view, is your child able to self-soothe, calm him or herself down and or regulate when he or she is in the midst of strong emotions? How? If not, please state this.

From your point of view, how does your child show or handle his or her emotions such as anger, sadness, or depression?

What do you believe are your child's strengths and gifts?

What do you believe are your child's challenges or areas in need of improvement?

Is there anything else that would be helpful for me to know about your child?

Is there anything that would be helpful for me to know about you or any other members of your family?

**Symptoms List:** Please check all that you believe apply.

- [ ] Sleep Problems
- [ ] Academic Worries
- [ ] Eating disorder or disordered eating
- [ ] Having a lack of friends
- [ ] Feelings of panic, fear, phobia
- [ ] Feeling sad or depressed
- [ ] Feeling Restless
- [ ] Low Self-esteem
- [ ] Aggression
- [ ] Chest Pain
- [ ] Heart Palpitations
- [ ] Self-Harm like cutting
- [ ] Feeling shy or awkward around others
- [ ] Stomach Problems
- [ ] Trouble Concentrating
- [ ] Grief or Loss
- [ ] Feelings of Hopelessness
- [ ] Disturbing Thoughts
- [ ] Mood Swings
- [ ] Suicidal
- [ ] Feeling Tense or Nervous
- [ ] Drug use
- [ ] Lacks Confidence
- [ ] Addictive Behaviors
- [ ] Alcohol Use
- [ ] Nightmares
- [ ] Feelings of Worthlessness
- [ ] Hallucinations
- [ ] Obsessive Thoughts
- [ ] Trembling
- [ ] Sexual Concerns
- [ ] Ideas of Harming others
- [ ] Blaming or Criticizing self
- [ ] Feeling Tired
- [ ] Anxiety
- [ ] Irritability
- [ ] Isolating Self
- [ ] Distractable
- [ ] Memory Problems
- [ ] Abusing Others
- [ ] Feeling a need to be on the go
- [ ] Illegal Behavior
- [ ] Abused by others
- [ ] Disorganized Thoughts
- [ ] Impulsive
- [ ] Chronic Pain
- [ ] Dizziness
- [ ] Problems at home
- [ ] Racy, speedy behaviors
- [ ] Sick often
- [ ] Problems with peers
- [ ] Poor judgment

# Informed Consent To Psychotherapy and Office Policies

*Please read the following carefully and ask for specifications about any element you do not fully understand.*

I, Rosanna Maria, have the following qualifications: Master's degree in clinical mental health counseling from Southwestern College in Santa Fe, NM working toward licensure under the supervision of Sabrina Bajakian LCPC. Workshops and trainings in mindfulness meditation, transpersonal psychotherapy, sandtray therapy, child development and parenting, art therapy, love addiction/love avoidance, and somatic trauma therapy.

I utilize a holistic framework incorporating the health of the body, mind and spirit. During the course of therapy, I am likely to draw on various theoretical approaches according to the problem presented and my assessment of what will be most beneficial to you. These approaches include humanistic, developmental, psycho-educational, transpersonal, narrative, behavioral/and or cognitive. If you have any questions about the therapeutic process please feel free to ask.

**Process, Benefits, and Risks of Psychotherapy:**

Participating in therapy can provide a number of benefits to you. These benefits include the possibility of reducing or eliminating psychological symptoms, improving interpersonal relationships, as well as resolving the specific concerns that led you to seek therapy. Benefits may also include increased capacity for intimacy, decreased negative ideation, decreased self-defeating behaviors, and improved mindfulness. Working toward these benefits require effort on your part. Psychotherapy is most beneficial with your active involvement including honesty and openness to make positive changes in your life. Psychotherapy requires action on your part including applying the skills, ideas, tasks, and suggestions discussed during the session in your every day life outside of therapy. Your feedback and views on your therapy is key to the process. Your feedback on your therapy is an important piece of the process.

During the therapeutic process, discomfort may be experienced by remembering or talking about unpleasant events, feelings, or thoughts. These discussions may evoke strong feelings of anger, sadness, worry, or fear. You may experience an increase in symptoms associated with anxiety, depression, or insomnia. I may challenge some of your assumptions and perceptions or propose different ways of viewing, thinking about, or handling situations. These challenges may evoke feelings of anger, upset, hurt, disappointment, or resentment, all of which are appropriate feelings to discuss within our therapeutic relationship.

Attempting to resolve the issues that prompted you to seek therapy may result in changes that were not originally intended. Psychotherapy may be a catalyst for you making new decisions about changing behavior, employment, schooling, housing, or relationships. Sometimes a decision that is positive for one family member may be viewed negatively by another family member. During the course of psychotherapy, things may feel like they are getting worse before they get better. Change can be easy and swift, but more often it will be slow and challenging before the relief is felt.

I consult with other health professionals regarding my clients in order to increase the effectiveness of the services I provide. I do not use first or last names or other identifying information during these consultations in order to assure that full confidentiality is maintained.
If at any point during our work together either one of us decides that I am not effective in helping you reach your therapeutic goals treatment can be terminated. In the event of termination, I would be happy to provide you with referrals to other therapists should you wish to continue treatment. With your written consent, I will provide him/her with the information needed for proper assessment and evaluation.

**Confidentiality:**

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where law requires disclosure. Law, in the following circumstances, may require disclosure:

1. When you have signed a "release of information form" from me or from another professional or agency stating exactly what information can be released and to whom it may be released;
2. When I believe that there may be a physical danger to you or to others though actions of yours, appropriate authorities, individuals and/or relatives will be notified.
3. When I become aware of actual or suspected child and or elder abuse, I am required by law to report such cases to the local welfare authorities.

The intent of such requirements is that a therapist has a legal and ethical responsibility to take action to protect endangered individuals from harm when the therapist's judgment indicates that danger exists. It is my policy to fully disclose these matters with my clients before any action is taken, unless there is a compelling reason not to do so.

**Client Rights:**

As a client, you have the right to review or receive a summary of your psychotherapy record at any time, except in limited legal or emergency circumstances, or when I assess that releasing such information may be harmful to you in any way. In such circumstances, I may provide you with a summary of your records, or may provide the records or its summary to an appropriate mental health professional of your choice.

Upon your authorization, I will release information to any agency/person you specify unless I assess that releasing information will be harmful to you in any way. You will be charged an appropriate fee for any professional time spent in responding to an information request regarding you or your treatment. I am happy to discuss any of these rights with you.

**Appointments, Availabilities and Emergency Procedures:**

Generally, meeting on a weekly basis at first gives both the therapist and the client a chance to develop an understanding of the problem as well as to get to know each other. The office does not have a receptionist; therefore you will almost always get the voicemail when you call due to my inability to answer the phone while with clients or after business hours. Please leave a detailed message and I will respond within 24 hours. Texting is a good option for scheduling or canceling appointments.

If I am unavailable during an emergency you may leave a message on my voicemail and I will attempt to get back in touch with you. In the event that I am unavailable and you need to talk to someone right away, you can call the 24-hour hotline at the Help Center at 406-586-3333 or go to the emergency room (Bozeman Deaconess Hospital, 406-585-1000).

If an emergency situation arises in which you are being harmed or are in danger of harming yourself or someone else, please call 911.

**Payments & Cancellation Policies:**

I offer a complimentary 20-minute initial consultation session. In this session, we will decide together if we will continue to work together. Subsequent therapy sessions are 50 min or 80 minutes long, dependent on the work we are doing. Length of sessions will be discussed up front and agreed upon together.

My fee is $75 per hour. Payment is required before session begins if it is a phone or Skype session or directly after if in office. Payment can be made via cash, check, or card. Please make checks payable to Rosanna Maria Psychotherapy & Coaching. There is a $30 fee for returned checks.

Cancellations happen. Since the scheduling of an appointment involves the reservation of time especially for you, a $25 fee will be charged for sessions missed without a 24-hour notice of cancellation. For no shows, the missed session is charged in full: $75. Please be sure to call or text-message in the event that you need to cancel.

**Social Media Policy:**

I do not accept friend requests, contact requests, or connect online with any current or former clients. I believe that adding clients as friends or contacts on social media sites can compromise your confidentiality and privacy. The exception to the rule is my business Facebook page and business Instagram account.

**I accept these terms during our professional relationship. Based on the terms of this agreement, I consent to participate in an evaluation and treatment with Rosanna Maria. I understand that this agreement can be withdrawn at any time.**

Client signature _____ Date _____

# Art & Soul Counseling, LLC

Rosanna Timmer, Psychotherapist
Supervisor: Sabrina Husain Bajakian, LCPC

TRANSFORM OBSTACLES CREATE CHOICE

DX:_____

Patient Name_____ Date of birth _____ Age_____ M or F

Address_____City_____State_____ Zip code_____

Social Security #_____ Marital Status_____ Student? Yes ___ No___

Home Phone #_____ Cell or Work# _____

Employer name & address_____

Responsible Party Name_____ Date of Birth_____

Social Security #_____

Referred by_____

## BILLING INFORMATION

***Primary Insurance***_____ Phone number_____

Address_____

Policy Holder name_____ DOB_____Policy#_____Group#_____

***Secondary Insurance***_____ Phone number_____

Address_____

Policy Holder name_____ DOB_____Policy#_____Group#_____

## FEE POLICY

Charge for the initial visit is $170 and subsequent visits are $150 per hour.
If you are covered by insurance, your insurance will be billed. However, until insurance accepts the claim, you will be fully responsible for cost of services. Balances over 30 days will be billed to the credit card on file and are subject to billing charges, collection services and fees. In the event any unpaid balance is placed for collections with any third party collection agency, a fee of **50%** of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of **50%** and the additional costs and charges listed above represent the actual costs incurred by Sabrina Bajakian & Art and Soul Counseling. LLC, to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

**A $100 fee will be charged for No Shows and appointments canceled without a 24-hour notice.** If you do not show up for two consecutive appointments, treatment will be terminated. Your signature on this form authorizes the release of any medical or other information necessary to process a claim to insurance and authorizes payment of medical benefits to Sabrina Bajakian, LCPC at Art and Soul Counseling, LLC.

## INFORMED CONSENT

My professional ethics and Montana State law require personal information be kept confidential. This means information about you is not revealed to other persons or agencies without your clear and deliberate permission. The written record of any information you share is kept in a locked file.

## HIPAA ACKNOWLEDGEMENT

Protecting your privacy is very important to me. By Federal law, I am required to inform you of my office HIPAA Privacy Practices. By signing this form, I am indicating that I have been provided a copy of Sabrina Bajakian & Art & Soul Counseling's, Notice of Privacy Practices related to health information. I understand that the Notice is subject to change, and I can obtain a current Notice by contacting this office.

Signature of Client Date Signature of Guardian Date

# Credit Card Authorization Form

Client Name _____

VISA _____ Mastercard _____ American Express _____ Discover _____

Name on Card _____

Card Number _____

Expiration Date _____ CVV Code (on back) _____

I, _____ , authorize Rosanna Maria Psychotherapy & Coaching LLC to charge my credit card for any and all balances on the account. This includes full session fees, insurance co-pays, and any missed appointment fees cancelled within 24 hours of scheduled appointments. I understand that my credit card information will be saved in my clinical file and this authorization remains in effect until cancelled.

_____ _____

Client/Legal Guardian Signature Date