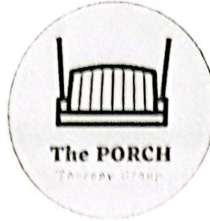
The Porch Therapy – Child/Teen Intake



Confidential Information

In order for us to be able to fully evaluate your child or teenager, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. Thank you!

Patient Information

Name ______________________ First Appointment Date ______________
Date of Birth ______________________ Age ________ Sex ______________
School ______________________ Grade ______________
SS# ______________________ Natural Mother ______________
Race ______________________ Natural Father ______________
Address ______________________ City ________ State ______ Zip ________
Home Phone # ______________________ Parent Work # ______________
Who is the child currently living with? ______________________
School/Employer ______________________
School Address ______________________ School Phone # ______________

Referral Source ______________________ Phone # ______________ Fax # ________
Address ______________________ City ________ State ______ Zip ________
Do we have your permission to release information to the referring professional? ________

Responsible Party – Parent/Guardian

Name ______________________ Relationship to Patient ______________
Date of Birth ______________________ Age ________ Sex ______________
SS# ______________________ Marital Status ______________
Spouse's Name ______________________ SS# ______________
Date of Birth ______________________ Age ________ Sex ______________
Spouse's Employer ______________________ Address ______________

Patient Name (print) ______________________ **Patient Signature** ______________
Responsible Party's Signature ______________________ **Date** ______________

Main Purpose of the Consultation (Please give a brief summary of the current problems)

____
____
____
____
____
____

Why Did You Seek The Evaluation At This Time? (What do you want this clinic to do for your child, yourself, or your family?)

____
____
____
____
____

Medical History

Current medical problems/medications (include dosage)______________________
____
____
____

Current supplements/vitamins/ herbs ______________________________________
____
____

Past Medical problems/medications ______________________________________
____
____
____

Primary Care Provider ____

Other doctors/clinics seen regularly ______________________________________
____

Any history of head trauma, concussion or significant accidents? (describe) __________
____
____

Ever any seizures of seizure like activity? ____________________________________

Prior hospitalizations (place, cause, date, outcome) ______________________________
____
____

Prior Abnormal lab tests (x-rays, EEG, etc.) ___________________________________
____

Allergies / Drug intolerances (describe) ______________________________________
____

Current Height ______________________ Current Weight____________________

Other medical history we may need to know ____________________________________
____
____
____
____

Prior Attempts to Correct Problems / Prior Psychiatric History (Please include contact with other professionals, medications, types of treatment, feelings about success or failure, etc.)

____
____
____
____
____
____
____
____
____

Current Life Stressors (Please list current factors that are a source of stress in the family)

____
____
____
____

<u>Family History</u>

Family Structure (who lives in the current household with the child, please give relationship to the child)

____
____
____
____

Current Marital or Relationship ____________ How satisfied? ____________

Significant Family Developmental Events (include marriage, separations, divorces, deaths, traumatic events, losses, abuse, etc.) ____

____
____
____

Natural Mother's History

Age ____________________ Occupation ____________

Highest Grade Completed in School ____________

Learning Problems ____________

Behavior Problems ____________

Marriages/Relationships ____________

Medical Problems ____

____

Childhood atmosphere (family position, abuse, illness, etc.) ______________

____

Has mother ever sought psychiatric treatment? Describe________________

____

Mother's alcohol/drug/nicotine use history ________________________

____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations, etc. (Describe) ________________________________

____

Natural Father's History

Age ______________________________Occupation ________________

Highest Grade Completed in School _______________________________

Learning Problems ____

Behavior Problems ____

Marriages/Relationships ______________________________________

Medical Problems ____

____

Childhood atmosphere (family position, abuse, illness, etc.) ______________

____

Has father ever sought psychiatric treatment? Describe________________

____

Father's alcohol/drug/nicotine use history ________________________

____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations, etc. (Describe) ________________________________

____

[If Applicable] Step or Adopted Mother's History (circle which)

Age ______________________________Occupation ________________

Highest Grade Completed in School_______________________________

Learning Problems ____

Behavior Problems ____

Marriages/Relationships ______________________________________

Medical Problems ____

____

Childhood atmosphere (family position, abuse, illness, etc.) ______________________________

____

Has step/adopted mother ever sought psychiatric treatment? Describe ______________________

____

Step or Adopted Mother's alcohol/drug/nicotine use history

____

____

[If Applicable] Step or Adopted Father's History (indicate which)

Age ______________________________ Occupation ______________________

Highest Grade Completed in School ______________________________

Learning Problems ______________________________

Behavior Problems ______________________________

Marriages/Relationships ______________________________

Medical Problems ______________________________

____

Childhood atmosphere (family position, abuse, illness, etc.) ______________________________

____

Has father ever sought psychiatric treatment? Describe ______________________________

____

Father's alcohol/drug/nicotine use history ______________________________

____

Siblings (name, ages, problems [behavior, medical, psychiatric], strengths, relationship to patient)

____

____

____

____

Child's Developmental History

Prenatal Events

Parents' attitudes toward their pregnancy ______________________________

Conception ease ______________________ Planned or Unplanned ______________________

Pregnancy complications (examples: bleeding, excess vomiting, medication, infections, smoking, alcohol/drug use, etc.) ______________________________

Birth and Postnatal Period

Birth Weight _______ Length ______ Labor Duration ____ Delivery Type ______________

Problems ______________________ APGAR Scores _____ Jaundice ____ Time in Hospital ____

Complications? ______________________________

Mother's Health After Delivery? ____

Post Delivery Blues? (describe duration/severity) ______________________________

____

Primary Caretaker for Child, First Year _____________________________________

Thereafter ____

Feeding History

Breast vs. Bottle ______________Age Weaned ______Food Allergies______________

Sleep Behavior (sleepwalking, nightmares, recurrent dreams, current problems getting up or going to bed) ____

____

Separations from Mother and/or Father (age, duration, reaction to) ______________

____

____

Toilet Training

Age reached bowel control: day ____night ____bladder control: day ____night ___________

Methods Used ______________Ease ___________Current Function______________

Motor Development (Please write in age, parentheses are approximate normal limits)

Rolls Over (3-5m)________ Sit Without Support (5-7m) _________Crawls (5-8m)_________

Walks Well (11-16m) _____Runs Wells (2y) ________________Rides Tricycle (3y)_____

Throws Ball Overhand (4y) _________________ Current Level of Activity_____________

Fine and Gross Motor Coordination ___________Compared to Peers? _______________

Language Development (Please write in age, parentheses are approximate normal limits)

Several Words besides dada, mama (1y) ______ Name Several Objects ex. ball, cup (15m) ____

3 Words Together ex. subject, verb, object (24m) _____Vocabulary ____________________

Articulation _______Comprehension _________Compared to Peers? ________________

Any Current Problems?____

Social Development (Please write in age, parentheses are approximate normal limits)

Smile (2m) ______ Shy with Strangers (6-10m) ___ Separates from Mother Easily (2-3y) ____

Cooperative Play with Others (4y) _______Quality of Attachment to Mother? ____________

___________________________Father?_____________________________________

Relationships to Family Members ____

Early Peer interactions ____

Current Peer Interactions ____

Special Interests/ Hobbies ____

Behavioral/Discipline

Compliance vs. Non-Compliance ____________ Lying/Stealing ______________________

Rule Breaking __________ Methods of Discipline ______________________________

Other Problems ____

____

Emotional Development

Early Temperament ______________________ Current Personality ______________

Mood ____________________________ Fears/Phobias ________________________

Habits ____________________________ Special Objects (blankets, dolls) __________

Ability to Express Feelings (describe) _____________________________________

____

School History

Current Grade ____________________ School Contact ________________________

Number of Schools Attended ________ Average Grades ________________________

Homework Problems? ______________ Specific Learning Disabilities ______________

Strengths ____

What have teachers said about the child/teen? _______________________________

____

____

Please bring school report cards and any state, national or special testing that has been performed

Overall Strengths (As Viewed By Parents) ____________________________________

____

____

Overall Strengths (As viewed By Child/Teen) __________________________________

____

____

Cultural/Ethnic and Religious/Spiritual Background ___________________________

____

Sexual Development

Gender Identity ______________ Any Problems/Concerns __________________________

____

Community Resources

Please check any resources or services you currently utilize.

Boys and Girls Club	Library
DFS	Medicaid / Medicare
Domestic Violence Shelter	Probation / Parole
Food Pantry	School Services
Food Stamps	SSI
Housing Assistance	WIC
Homeless Shelter	Other ___________________________

Support System

Please describe your support system (include family and close friends)

____

____

____

____

____

____

Organizational Involvement

Please describe any organizations in which you actively participate (ex. churches, community, etc.)

____

____

____

____

Sensitive Topics We understand that many of the following issues can be sensitive topics but in order to best serve your child / teen we need to have as much information as possible. This is not used in anyway as a judgement but to address difficulties that your child / teen may be facing.

Physical / Sexual Abuse / Trauma History ______________________________

____

____

____

____

Drug / Alcohol / Nicotine History ______________________________

____

____

____

____

Depression Pre-Screen

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

*Follow-up if indicated

Risk Assessment In the past few weeks, have you wished you were dead? *Yes / No*

In the past few weeks, have you felt that you or your family would be better off if you were dead? *Yes / No*

In the past week, have you been having thoughts about killing yourself or others? *Yes / No*

Have you ever tried to kill yourself? *Yes / No* If yes, when / how ______________________________

____

____

____

____

Are you having thoughts of killing yourself or others right now? *Yes / No*

*Follow-up with any "yes" answers

STATEMENT OF UNDERSTANDING AND CONSENT TO EVALUATION/TREATMENT

Insurance plans are highly variable, and you are responsible for understanding your benefits. Calling the toll-free number on your insurance card and asking for a thorough explanation of your out-patient mental health benefits is advisable. Make sure you ask about services covered, deductibles, co-insurance payments, whether or not you are limited to a certain group of providers and the kinds of credentials your provider needs to have. Full payment is expected for all services delivered regardless of insurance coverage.

You will receive regular statements only if your account has a balance. A fee of $35 will be charged on all returned checks.

CANCELLATION POLICY: If you plan to miss your appointment, we request that you **notify the office 24 hours in advance to avoid a charge. A no-show appointment will result in a $50.00 charge,** as this time could have been scheduled for another individual. This charge is your financial responsibility and will not be filed with your insurance company.

I/We have read and understand the above Cancellation Policy: Initial ________________ Date ____________

CONFIDENTIALITY:

Physician Referrals: Information relevant to your case may be discussed with your referring physician in order to plan an effective coordination of treatment, unless the patient has specifically advised therapist not to consult with referring physician.

Self Referrals: Information concerning a patient will not be discussed or disclosed to anyone, except as required by law, without the express, prior written consent of the individual.

Dangerous Situations: If it is believed that the patient, another person, or property is at substantial risk of harm, or it appears that an illegal act or threat thereof has been committed, it is the therapist's obligation to disclose, as required by law, what information is necessary to prevent harm or protect against criminal acts.

LEGAL PROCEEDINGS: If you become involved in legal proceeding that require participation of a therapist at The PORCH Therapy Group, you will be expected to pay for the therapist's time, even if called to testify by another party. Because of the complicated nature of legal involvement, you will be charged $150 per hour for preparation time (minimum of 3 hours) and attendance at any legal proceeding.

CONSENT TO EVALUATION/TREATMENT:

The undersigned is/are applying for and consenting to treatment by:____________________. (therapist)

I/We understand that any release of information from clinical record can only be made with written prior consent by all the undersigned.

All adults (non-minors) or guardians who are receiving services at this office must sign this document prior to receiving treatment.

Therapist's at The PORCH are independent practitioners. All checks are to be made out to __________________.

I/We understand the above and hereby consent to evaluation/treatment.

Patient: ____ Date: __________________

Legal Guardian Signature (if applicable): __________________________ Date: __________________

Consent for Mental Health Treatment of a Minor

Minor's Name____________________________ Date of Birth_______________

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek psychotherapy and/or psychological assessment from the professional staff at The PORCH Counseling Group.

The mental health provider responsible for the care, ___________________________,

has explained to me the proposed treatment plan and that treatment will not be delayed if an emergency exists. This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

Any questions relating to this form or the proposed treatment can be directed to your therapist at The PORCH Counseling Group by calling 417-815-6313.

_________________________________ _________________________________

(print name of parent/guardian) (signature of parent/guardian)

____

(date)

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary/narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: ______________________________ Date of Birth: ________________

The information you may release subject to this signed release form is as follows:

- Complete Records
- Treatment Plan
- Progress Notes
- Demographic Information
- Billing Records
- Treatment Summary/Narrative
- Consultations
- Verbal Reports

Release my protected health information to the following physician/person/facility/entity and/or those directly associated with my medical care:

Name	Affiliation	Address	Phone#	Email

Signatures:

____
Patient Name

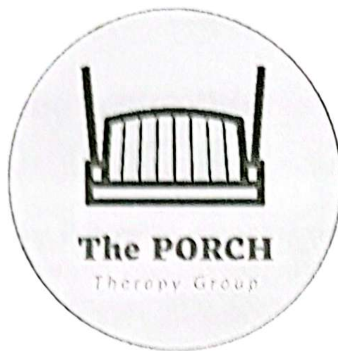
____
Patient Date of Birth or Social Security

____
Date

____
Signature of Patient or Personal Rep.

____
Printed Name of Patient or Personal Rep.

____
Description of Personal Rep. Authority



Appointment Reminder Preference

Name: ______________________________

The PORCH Therapy Group may notify you of your next appointment 24-48 hours in advance as a courtesy reminder. Please choose one reminder option.

☐ Yes, I would appreciate a phone reminder. Please call me prior to my appointment at ___________________________. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ Yes, I would appreciate a text reminder. Please text me prior to my appointment at ___________________________. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ No, I would prefer not to be reminded of appointments and will keep up with them myself.

Client ____ Date______________

Staff____ Date______________

The PORCH Therapy Group
504 W Main, West Plains, MO 65775
417-815-6313

Health Insurance Portability Accountability Act (HIPAA) Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

©2015 by K2 Visionaries, LLC all rights reserved.

5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Missouri Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment*** – I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.

©2015 by K2 Visionaries, LLC all rights reserved.

- *Right to Confidentiality* – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- *Right to Amend* – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- *Right to a Copy of This Notice* – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- *Right to Choose Someone to Act for You* – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- *Right to Choose* – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- *Right to Terminate* – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- *Right to Release Information with Written Consent* – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes,

©2015 by K2 Visionaries, LLC all rights reserved.

however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Missouri Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

______________________________________ __________________
Client/Legal Guardian Signature Date

____
Printed Name

______________________________________ __________________
Client/Legal Guardian Signature Date

____
Printed Name

______________________________________ __________________
Therapist Signature Date

©2015 by K2 Visionaries, LLC all rights reserved.