VALLEY CHRISTIAN COUNSELING

CHILD CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here remains confidential.

Please describe the main issue, reason, or event that has led you to seek therapy services for your child:

_____
_____
_____
_____
_____
_____

Child's name: _____ Date of Birth: _____
Age: _____ Gender: □ M □ F
Name of person completing this form: _____
Relationship to child: _____ Form Completion Date: _____
Home Address: _____
Who does this child live with? _____
School: _____ Grade: _____
How did you hear about me? _____

MOTHER CONTACT INFORMATION

Name: _____ Date of Birth: _____
Address (if different): _____
Email: _____
Cell Phone: _____ May we leave a message? _____
Home Phone: _____ May we leave a message? _____
Relationship status (Check all that apply):
□ Married □ Separated/Divorced □ Live with partner □ Single □ Widowed
Employment status and title: _____
Faith/religious orientation: _____

FATHER CONTACT INFORMATION

Name: _____ Date of Birth: _____
Address (if different): _____
Email: _____
Cell Phone: _____ May we leave a message? _____
Home Phone: _____ May we leave a message? _____
Relationship status (Check all that apply):
□ Married □ Separated/Divorced □ Live with partner □ Single □ Widowed
Employment status and title: _____
Faith/religious orientation: _____

STEPMOTHER OR STEPFATHER CONTACT INFORMATION (if applicable)
Name: _____ Date of Birth: _____
Address (if different): _____
Email: _____
Cell Phone: _____ May we leave a message? _____
Home Phone: _____ May we leave a message? _____
Relationship status (Check all that apply):
□ Married □ Separated/Divorced □ Live with partner □ Single □ Widowed
Employment status and title: _____
Faith/religious orientation: _____

EMERGENCY INFORMATION
In case of an emergency please contact: _____
Relationship to child: _____
Phone: _____

DEVELOPMENTAL HISTORY
Was this a planned pregnancy? □ yes □ no
Was the child adopted? □ yes □ no If yes, does the child know he/she is adopted? □ yes □ no
If adopted, how old was the child at adoption? _____

Were there any problems during pregnancy? (ex: diabetes, high blood pressure, etc)
_____
_____
Were there any problems during labor and delivery?
_____
_____
Were there any problems 3-4 month post-delivery? (ex: feeding, sleeping, colic, etc)
_____
_____

Developmental Milestone	**Age Reached (n/a if not applicable)**
Sat alone	
Crawled	
Stood alone	
Walked alone	
Fed self	
Toilet training started	
Toilet training ended	

Was your child delayed in any of the following skills? (Check all that apply)
□ Sitting □ Crawling □ Walking □ Speaking words □ Speaking in sentences □ other _____

Is your child having any problems with his/her sleep habits? □ yes □ no
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ other _____

CHILDCARE/EDUCATIONAL HISTORY

Please describe any difficulties your child is having with the childcare provider or school:

_____
_____
_____
_____

Does anyone other than mom/dad/parent have childcare responsibilities for your child? If so, please list name and relationship:

_____

Schools attended (including daycare and preschool), when, and reason for leaving (if applicable)

1. _____
2. _____
3. _____
4. _____

Has your child been suspended or expelled from any school before? If so, please explain:

_____
_____

Does your child receive any school accommodations? □ yes □ no Circle one: IEP or 504

If yes, what services/accommodations do they receive? _____

_____

* If so, please attach a copy of their current plan to this form.

Specialized services such as: (circle all that apply)

Physical therapy Occupational Therapy Speech and Language Services

Names and dates of providers: _____

HEALTH INFORMATION

Does your child currently have a primary physician? □ yes □ no

If yes, who is it? _____

Is your child currently seeing more than one medical health specialist? □ yes □ no

If yes, please list: _____

_____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, asthma, etc.):

_____
_____

Is your child currently on medication to manage a physical health concern? If yes, please list:

_____
_____

EXERCISE

How would you describe your child's physical activity?

□ little to no exercise □ a few times a month □ a few times a week □ nearly every day

APPETITE

Is your child having any difficulty with appetite or eating habits? □ no □ yes

If yes, check where applicable and explain: □ Eating less □ Eating more □ Bingeing □ Restricting

_____

Has he/she experienced significant weight change in the last 2 months? □ no □ yes

SUBSTANCE HISTORY AND USE

Please list any legal/illegal substances used by your child in the past and/or present including alcohol, and tobacco (current/past use, how much/often, last time used):

_____

_____

TREATMENT HISTORY

Is your child currently receiving any other mental health services?

□ yes □ no

Has your child had previous psychotherapy?

□ no □ yes, with (previous therapist's name) _____

Is your child currently taking prescribed psychiatric medication (antidepressants or others)?

□ yes □ no

If yes, please list: _____

Prescribed by: _____

Has your child ever experienced any of the following?

Symptom	**Circle one**	**If yes, please explain (include frequency)**
Extreme depressed mood	Yes / No	
Dramatic mood swings	Yes / No	
Rapid speech	Yes / No	
Extreme anxiety	Yes / No	
Panic attacks	Yes / No	
Phobias	Yes / No	
Sleep disturbances	Yes / No	
Hallucinations	Yes / No	
Unexplained losses of time	Yes / No	
Unexplained memory lapses	Yes / No	
Alcohol/substance abuse	Yes / No	
Frequent body complaints	Yes / No	
Eating disorder	Yes / No	
Body image problems	Yes / No	
Repetitive thoughts (e.g. obsessions)	Yes / No	
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No	
Defiance	Yes / No	
Lack of conscience	Yes / No	
Lack of empathy	Yes / No	
Hyperactivity	Yes / No	

Low energy	Yes / No	
Advanced sexual knowledge	Yes / No	
Running away	Yes / No	
Chronic headaches/stomachaches	Yes / No	
Sensitivity to sounds, noises, textures	Yes / No	
Anger	Yes / No	
Masturbates excessively	Yes / No	
Bed wetting	Yes / No	
Day wetting	Yes / No	
Soiling clothing	Yes / No	
Peer problems	Yes / No	
Overly aggressive toward people and/or animals	Yes / No	
Homicidal thoughts	Yes / No	
Hurts self intentionally	Yes/No	
Other		

SUICIDE ASSESSMENT

Has your child had thoughts of harming him/herself recently? □ yes □ no
If yes, how often: □ frequently □ sometimes □ rarely □ never
Has your child had them in the past? □ yes □ no
If yes, how often: □ frequently □ sometimes □ rarely □ never
Has your child attempted suicide? □ yes □ no If yes, when? _____

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g. sibling, parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	
Adoption	Yes / No	
Abuse	Yes / No	
Other (use box to explain)		

TRAUMA ASSESSMENT

Has your child personally experienced or witnessed any of the following? If, Yes, was he/she the victim or the witness?

Experience	**Please circle**	**Victim**	**Witness**	**OTHER INFORMATION**
Physical abuse	Yes / No			
Sexual abuse	Yes / No			
Emotional/mental abuse	Yes / No			
Neglect	Yes / No			
Abandonment	Yes / No			
Community violence	Yes / No			
Bullying	Yes / No			
Natural Disaster	Yes / No			
Other	Yes / No			

CHANGES/STRESSORS/LOSSES

In the last year, has your child experienced any significant life changes, stressors or losses? (Examples include moving, new job for a parent, changes in the family, divorce, new siblings, loss of a pet, loss of a family member or friend, serious illness, parent incarceration, etc.).
If yes, please list them here:

_____
_____
_____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider your child to be religious? □ no □ yes
If yes, what is his/her faith? _____
If no, do you consider your child to be spiritual? □ no □ yes
Would you like your therapist to incorporate faith/spirituality into the sessions? □ no □ yes

Are you looking for court related services? If yes, please explain.

_____
_____
_____

What do you consider to be your child's strengths?

_____
_____
_____

What do you consider to be your child's weaknesses/limitations?

_____
_____
_____

What do you like most about your child?

_____
_____
_____

What are effective coping strategies that your child has learned?

_____
_____
_____

What are your goals for your child's therapy?

_____
_____
_____

VALLEY CHRISTIAN COUNSELING
Informed Consent

Overview
Welcome to Valley Christian Counseling. The following information is to assist you in establishing your expectations for psychotherapy and functions as an agreement between you and your therapist. Please read the following carefully and complete all sections before the first session. Please feel free to call with any questions or concerns throughout the course of treatment.

Sessions
Therapy appointments are approximately 45-55 minutes in duration, however longer sessions are also available upon advanced request. The number of sessions is determined by both the therapist and the client depending on the client's individual needs.

Cancellation Policy
A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled without 24 hours' notice, the clinician reserves the right to charge you a missed/cancelled appointment fee equal to your agreed upon session rate.

Appointment Reminders
To better serve our clients, our staff strives to provide reminders for your appointment approximately 24-48 hours in advance. However, please make efforts to set self-reminders in the event we are not able to send them.

Emergency Options and Additional Resources
If you are unable to reach our office during normal business hours and are experiencing a crisis or medical emergency please call 911 or head to your nearest emergency room.

Records
Your professional records may include information regarding your reason for seeking therapy, a description of the impact your problems may be having on your life, your treatment goals and your progress toward said goals, your medical and social history, your billing records, and any reports received from other clinicians. You have the right to review your records at any time however, it is recommended that the records be reviewed in the presence of your therapist before viewing them individually. A fee may be applied to the request of your records. Your records are stored in a locked filing cabinet behind two locked doors, and will be stored for 7 years (per requirements of the Alabama Board of Social Work) before being properly destroyed.

Offsite Consultation
Consultations are sometimes requested by other professionals involved in your care. In the event that you or another professional request a consultation, your clinician reserves the right to bill at the hourly rate for consultation services. It is important to note that billable time may also include travel and prep time.

Contacting your Clinician
If you need to contact your clinician, please call Valley Christian Counseling Center and leave a message with the receptionist or on the appropriate extension. Your therapist will periodically check messages, and return your call as soon as possible.

Minors and Parents
Children under the age of 14 cannot consent to therapy on their own, however in the State of Alabama a minor child over the age of 14 may seek therapeutic services without the consent or knowledge of their parents/guardians. Children over the age of 14 have the right to privacy and the parents are not privy to confidential information, unless a release has been obtained. The Clinician will strongly urge the teenager to sign said release as treatment is often inhibited when guardians are not involved in the process. Clients under the age of 14 cannot consent for themselves and therefore will need the permission of a guardian to seek therapeutic services. If a child is in danger or is a danger to someone else, the therapist will notify the parents of this concern as well as the appropriate authorities if necessary. Before, giving sensitive information to parents, the clinician will discuss the matter with the child, if possible, and do their best to mitigation any objections and explain the benefits of guardian support.

Release of Information
Valley Christian Counseling is not a HIPAA covered entity; however, your therapist is subject to all ethical and legal standards that protect your confidentiality. We will only disclose your personal information given legal obligations due to a duty to report, and/or given your written authorization.

Limits on Confidentiality
1. Occasional consultations with other mental health professionals about a case are helpful or even necessary in order to provide quality care. We make every effort to ensure your confidentiality during this process.
2. If you or a minor in your care are a harm to yourself or others, I have a duty to report in order to prioritize your safety.
3. The following are some examples of situations in which I may be required or legally permitted to disclose information without your consent or authorization:
    a. Requests made from court order
    b. In the event I become the defendant in a case filed against me I have the right to release privileged information that may be relevant to my defense.
4. I am considered a mandatory reporter, meaning if I suspect that any vulnerable population is being abused and/or neglected that I must report to the appropriate authorities.

_____ _____
Print Client or Guardian Name Date

_____ _____
Client or Guardian Signature Date

_____ _____
Clinician's Signature Date

*The above signature certifies that I understand that I am consenting to counseling services, and that I understand the limits of confidentiality within those services.

VALLEY CHRISTIAN COUNSELING
Client Rights

As a client, your child can expect:
• Humane care and treatment, with respect and consideration
• Privacy and confidentiality when seeking or receiving services except in the case of life-threatening situations or conditions
• Confidentiality of your health records
• Accurate information concerning diagnostic impressions, treatment, and risks
• Active participation in decisions regarding your own treatment
• Accessible information regarding the scope and availability of services
• Information about any legal reporting requirements regarding any aspect of screening or treatment
• A copy of your records upon request and written authorization
• Ability to file a complaint with the director of VCC regarding any concerns related to the privacy, confidentiality or security of your medical record
• Competent treatment in a respectful environment that acknowledges your dignity and worth
• To gain knowledge regarding strategies and therapy techniques used to aid in your treatment.
• Participation in establishing and reestablishing goals throughout therapy
• Option to participate in or refrain from services (except when mandated)
• Ability to request referrals for alternative services

_____ _____
Print Client or Guardian Name Date

_____ _____
Client or Guardian Signature Date

_____ _____
Clinician's Signature Date

VALLEY CHRISTIAN COUNSELING
Financial Agreement

Thank you for choosing Valley Christian Counseling to be your mental health provider.
We are committed to providing the best care possible. It is important that you understand that payment for services is considered part of your treatment; therefore, the following information explains our financial policies. We ask that you sign this form as an indication that you have read and agree with the information presented.

Reimbursement/Insurance Coverage
Your clinician does not accept insurance. However, you may submit to your insurance for reimbursement as your clinician would be considered an Out-of-Network Provider. Your clinician does not determine how your insurance will reimburse counseling services, that is between you and your insurance company. Your clinician's fees are subject to change and you will have advance notice of those changes as they arise.

Methods of Payment
We ask that you pay in full upon the time of services, unless previously agreed upon by you and your therapist. We accept most forms of payment including cash, check, or credit card.

Unpaid Balance
If you accrue an unpaid balance, we ask that you make arrangements to pay balance within 30 days. In the event that we cannot reach you to collect payment, Valley Christian Counseling may pursue reimbursement by submitting a claim to small claims court, or hiring a collections agency. Payment plans may be offered when requested with approval from director of VCC. Confidential information may be shared in claims court or to collections agency on as needed basis.

Late Cancellation/No Show Fees
If cancellations have not been made within 24 hours of the appointment or client did not show up for the session, the client is subject to a no-show fee. Exceptions are made in cases of emergencies. Late cancellation/no show fee is the entire session fee of $130.00. Grace is often offered, especially in unforeseen circumstances. Your practitioner asks for communication and in response fees may be waved at your practitioners' discretion.

Court Related Fees
Clients who require court related services can expect a rate of $200 per hour. Court related work can include, but not limited to, consultations, phone calls, travel time, depositions, and time spent at court. There is a minimum retainer fee of $1000 to appear/testify in court. Payment must be received 48 hours prior to the court appearance. Subpoenas must be received within 48-hour notice or client may be subject to an additional charge of $200. In the event that the court date is rescheduled with less than 72 business hours, the clinician reserves the right to charge an additional fee of $300 in addition to any previous accrued fees. It is important to note that any given testimony may not result in your favor. In the event that you lose your case, you will still be responsible for court related fees.

Statement of Understanding

I certify that I understand the above statement and I agree to its terms. By signing below, I am stating that I have read and agree with the financial fees set by my practitioner. I understand that Valley Christian Counseling and/or my practitioner reserve the right to adjust or lower that fee on as needed basis.

_____ _____

Print Client or Guardian Name Date

_____ _____

Client or Guardian Signature Date

_____ _____

Clinician's Signature Date