Christian Counseling Services

Minor Intake Assessment and Consent Form

Please complete this form prior to first session

General Information

Client's Name: _____ DOB: _____ Age: _____

Gender: Male ☐ Female ☐

Address: _____ City: _____ State: _____ ZIP: _____

Parent/Guardian Name (1) _____ Relationship: _____

Parent/Guardian (1) Phone Number(s): Home _____ Cell _____

Work _____ Other _____

Parent/Guardian (1) email: _____

OK to leave message *(check all that apply)*: Home ☐ Cell ☐ Work ☐ Other ☐ Email ☐

Parent/Guardian Name (2) _____ Relationship: _____

Parent/Guardian (2) Phone Number(s): Home _____ Cell _____

Work _____ Other _____

Parent/Guardian (2) email: _____

OK to leave message *(check all that apply)*: Home ☐ Cell ☐ Work ☐ Other ☐ Email ☐

Custody Terms (if applicable*): Does not apply ☐

_____

_____

*If there are formal custodial arrangements, please bring appropriate court documentation to first session.

Referral Information

How did you hear about Christian Counseling Services? _____

Services Needed: Child/Adolescent Therapy ☐ Family Therapy ☐ Medical Referral ☐

Person completing this packet: Parent ☐ Foster Parent ☐ Legal Guardian ☐ Client ☐ Other ☐

Please describe the main problem/reason for seeking therapy: _____

_____

_____

_____

_____

What changes or improvements are expected with treatment? _____

_____

_____

_____

Emergency Contact

Primary

Name: _____ Relationship: _____

Phone Number: _____ Is this person allowed to pick up the client? Yes ☐ No ☐

Secondary

Name: _____ Relationship: _____

Phone Number: _____ Is this person allowed to pick up the client? Yes ☐ No ☐

Is there anyone else you wish to use as an emergency contact and/or client pick up?

_____

_____

I confirm that the information contained in these forms is true and correct to the best of my knowledge.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Presenting Problem Checklist (Please indicate all concerning behaviors):

Issue	**Past**	**Present**	**Issue**	**Past**	**Present**
Crying, sadness, depression			Temper tantrums/outbursts		
Lost enjoyment in usual activities			Irritability/anger		
Tiredness/fatigue			Excessive arguing		
Anxiousness/nervousness			Disobedience/defiance		
Panic attacks			Intentionally annoying to others		
Excessive worry			Gets annoyed easily		
Low self-esteem			Aggressive behavior/fighting		
Withdrawn			Impulsive/acts without thinking		
Change to sleep patterns			Negative thoughts		
Nightmare/night terrors			Blames others/refuses responsibility		
Sleepwalking			Refusal to complete chores		
Poor bladder control/bedwetting			Intentionally hurts people or animals		
Change in eating patterns/appetite			Intentionally destroys property		
Preoccupied with weight/size			Uses inappropriate language/swears		
Extreme weight loss or gain			Inappropriate sexual behavior		
Usual fears or phobias			Accesses pornography		
Headaches/stomachaches			Threatened/attempted running away		
Twitches or involuntary tics			Sneaking out		
Hallucinations			Academic decline		
Has rituals, habits, superstitions			Lack of motivation		
Repeats unnecessary behaviors			Easily distracted		
Poor hygiene or self-care habits			Trouble concentrating		
Self-injury			Fidgeting/excessive activity		
Homicidal thoughts			Cannot complete tasks		
Preoccupied with death			Disruptive		
Suicidal thought(s)/attempt(s)			Questioning sexual orientation		
Lying			Physical Abuse		
Stealing			Sexual Abuse		
Problem with authority			Emotional/Mental/Verbal Abuse		
Legal issues			Drug/alcohol use		

Additional behavioral or emotional concerns/symptoms _____

_____

_____

Please describe the most important/distressing symptoms (Severity = 1-10):

Symptom #1: _____

Severity: _____ Frequency: _____ Duration: _____

Symptom #2: _____

Severity: _____ Frequency: _____ Duration: _____

Symptom #3: _____

Severity: _____ Frequency: _____ Duration: _____

Symptom #4: _____

Severity: _____ Frequency: _____ Duration: _____

What are some of the client's strength? _____

_____

What are some of the client's weaknesses? _____

_____

If abuse is indicated, please provide additional details (dates, locations, offenders, impact to family/client, action taken): N/A ☐ _____

_____

_____

If self-harm, suicide, or homicide is indicated, please provide additional details (threat, victim, action taken, timeline, etc.): N/A ☐ _____

_____

_____

Does the client have a current intent/active plan for harm to themselves or someone else? Yes ☐ No ☐

Developmental History:

Please indicate any complications related to the pregnancy, labor, and birth of the client:

Mother used drugs		Health problems during pregnancy		Premature birth	
Mother used alcohol		Problems with labor		Admitted to NICU	
Mother was on bed rest		Problems with delivery		Born with cord around neck	

As an infant/toddler, please indicate any difficulties the client experienced in the following areas:

Eating/feeding self		Turning over		Crawling/walking	
Toilet training		Language development		Sleeping thought the night	
Following basic commands		Separating from parents		Interacting with other children	

Please describe: N/A ☐ _____

_____

_____

Pleased describe any major health issues the client had up to five (5) years old (such as seizures, severe colic, organ defects, injuries, major infections, etc.): N/A ☐

Issue	**Age**	**Outcome**

Was the client breast fed? Yes ☐ No ☐

Is the client a multiple? Yes ☐ No ☐

Please rate the client's activity level up to age five (5):

Very Active ☐ Active ☐ Average ☐ Limited ☐ Inactive ☐

Approximately how long did toilet training take? _____

Family History

Please indicate all members in the client's immediate family.

Name	Age	Relationship	Living at home (Y/N)	Occupation/Grade

Current living situation: _____

_____

Previous living situation (previous year): _____

_____

Does the client live in a single-parent household?: Yes ☐ No ☐

Does the client live with a blended family?: Yes ☐ No ☐

Specify the overall level of family conflict: High ☐ Moderate ☐ Low ☐

How well does the client get along with his/her siblings?: _____

_____

With which family member is the client the closest?: _____

Which family relationships are tense/distant/negative?: _____

_____

_____

Are there any current marital problems that could be affecting the client?: Yes ☐ No ☐

If yes, please describe: _____

_____

What are family strengths?: _____

_____

What are family weaknesses?: _____

_____

Is there any history of the following in the past two biological generations (continue on back if needed)?

Issue	**Person**	**Comments**
Mental Illness		
Abuse		
Addiction		
Learning Disabilities		
Birth Defects		
Significant Legal Issues		

What type of discipline is used at home?

Type	**Frequency**	**Effectiveness (1-10)**	**Administered by**
Verbal reprimand			
Time out/Isolation			
Removal of privileges			
Rewards			
Physical punishment/spanking			
Natural consequences			
Threats/warnings			
Giving in or avoiding confrontation			
Emotion coaching			

Please indicate the following regarding family dynamics:

Our family is warm and loving Yes ☐ No ☐

Family members are respectful to one another Yes ☐ No ☐

Our home is very chaotic Yes ☐ No ☐

Our family feels connected Yes ☐ No ☐

Our home has a lot of conflict Yes ☐ No ☐

How has the family been impacted by the client's issue(s)?: _____

_____

_____

In what ways is the family willing to be involved by the client's treatment?: _____

_____

_____

What is the role of any other family member(s) in the client's problem(s)?: _____

_____

_____

Social History

Please indicate the items that describe the client in social situations:

Prefers to be alone		Few friends/feels lonely	
Shy/withdrawn		Many friends/popular	
Outgoing/friendly		Poor personal boundaries	
Gravitates toward "problem kids"		Has inappropriate interactions with others	
Is oversensitive/easily offended		Gets teased/bullied	
Physical fights with others		Teases or bullies others	
Poor peer relationships		Frequent conflict with others	
Difficulty sharing or negotiating with others		Tends to be demanding or bossy	
Makes friends easily		Shows good manners/respects others	

Please describe client's personality with a few adjectives: _____

_____

Is the client generally comfortable is social situations?: Yes ☐ No ☐

Has the client completed puberty?: Yes ☐ No ☐

Please describe any age-inappropriate sexual activity or behaviors that have been observed: _____

_____

Client relationship status: Single ☐ In a relationship ☐ "It's complicated" ☐ N/A ☐

If a relationship is indicated, please indicate duration: _____

Is client sexually active?: Yes ☐ No ☐ Not sure ☐

If yes, are birth control methods being utilized?: Yes ☐ No ☐ Not sure ☐

Does the client display any signs of sexual orientation or gender identity issues?: Yes ☐ No ☐

If yes, please explain: _____

_____

Is there any other important information regarding the client's sexual maturation, activities, or health?

_____

_____

_____

Medical/Treatment History

Please indicate client's major health problems and/or surgeries:

Condition	Yes	Age	Details
Serious infections			
Major surgeries			
Extended hospitalizations			
Significant injuries			
Allergies			
Drug abuse/addiction			
Sexually transmitted disease			
Chronic illness			
Genetic disorders			

Additional comments: _____

_____

_____

_____

Please indicate any medications the client is taking:

Medication	Dosage/Duration	Purpose

Has the client ever had mental health treatment before? (Continue on back if needed.)

Provider	Reason/Services	Purpose

Has the client ever been hospitalized for psychiatric issues? Yes ☐ No ☐

Has the client ever been admitted for residential/in-patient treatment? Yes ☐ No ☐

Has the client ever been seen by a psychiatrist/psychologist? Yes ☐ No ☐

When was the last time the client was assessed by a General Practitioner? _____

Does the client complain of frequent aches or pains? Yes ☐ No ☐

If yes, please describe: _____

_____

School/Academic History

Name of school: _____ Institution type: _____

Grade (current or highest completed): _____ Average performance (grades A-F): _____

Does the client have a diagnosed learning disability? Yes ☐ No ☐

If yes, please specify: _____

Treatment/Action plan: _____

If yes, does the school have an Individual Education Plan (IEP)? Yes ☐ No ☐

If yes, what are the current accommodations? _____

_____

Has the client ever attended a special education program? Yes ☐ No ☐

If yes, please describe type and duration: _____

_____

Please check any significant education issues:

Issue	**Yes**	**Grade**	**Issue**	**Yes**	**Grade**
Disruptive in class			Tutoring needed		
Oppositional with teachers			Detention		
Failure to complete/submit work			Suspension/expulsion		
Refusal to go to school			Poor relationship w/ teacher(s)		
Excessive absences/truancy			Repeated grade levels		

Please clarify: _____

_____

_____

Please summarize the client's general progress in school (including academic performance, social behaviors, testing, significant accomplishments, extracurricular activities, etc.): _____

_____

_____

_____

Current Stressors

Please indicate any major changes that have occurred in the family/home environment in the last 12 mos.

Stressor	**Impact (1-10)**	**Stressor**	**Impact (1-10)**
Financial problems		Mental illness diagnosis	
Recent/frequent moving		Major illness/hospitalization	
Divorce/Separation		Legal problems	
Remarriage		Onset of drug or alcohol use	
Separation from siblings		Probation	
Job change		Loss of friend/relative/pet	
Significant change in routine		Observed or experienced abuse	
Marital problems/parental conflict		Housing problems	
Adoption/foster care		Custody battle	

Please clarify: _____

_____

_____

_____

_____

Additional comments: _____

_____

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Christian Counseling Services

Consent for Treatment of a Minor

To be signed by all parents and/or legal guardians

I/we _____ ,
the parent(s)/legal guardian(s)of _____, age _____
(hereinafter referred to as "the minor"), give authorization and consent for Christian Counseling Services to provide counseling to the minor.

Authorization and consent are given with the understanding that, although rare, there are potential risks associate with counseling children under the age of 18. I/we fully understand these potential risks and choose to allow the minor to participate in counseling. I/we release Christian Counseling Services from any liability for discomfort related to counseling services provided.

I/we have read and fully understand this authorization and release form. I/we understand that this form should not be signed if I/we do not fully understand or if all my/our questions have not been answered satisfactorily.

Printed Name: Printed Name:

_____ _____

Signature: Signature:

_____ _____

Date: Date:

_____ _____

Social Media/Electronic Communications Consent Form

Email Policy: Email is a convenient way to maintain a stream of communication between clients, especially with parents who are not present during their child's individual session. However, some potential risks of using email:

- Typos and errors of email to an incorrectly typed email address, tone interpretation and errors in details or data.
- Email accounts can be "hacked," giving a 3rd party access to email content and addresses.

Texting Policy: Texting is acceptable, only to communication regarding non-clinical issues. These include topics such as scheduling an appointment, changing an appointment, notification of running late to an appointment, receipt requests, and directions to the office. Texts regarding clinical issues, such as a family issue, personal difficulties, etc., are not acceptable. I will not respond to these texts and will delete them immediately.

Social Media/Internet

So much information about a person can be found online, either through company websites, social media, business reviews, and more. It's the age we live in, and therefore it's important we understand boundaries with regards to social media and any other information online.

- Client and therapist will NOT perform online researches on one another for gathering personal information. To maintain the unbiased commitment of the counseling relationship, the counselor agrees to refrain from prior subjective researching of clients that could create a bias *(This does not pertain to a client researching the professional background of a therapist and other service/practice information).*
- Client and therapist will not request or agree to be "friends" on personal social media sites, including Facebook, Twitter, Instagram or others. Clients may "like" or "follow social media pages that are offered by the therapist as a part of their professional work *(i.e. a professional Twitter page the counselor has can be "followed" by the client or the Facebook page of the site you are receiving services at can be "liked").*
- If a client follows the therapist on a professional social media site, comments should not indicate there is a client-therapist relationship. Any comments made that potentially disclose such a relationship will be removed immediately.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

CONSENT TO RECORD COUNSELING SESSIONS

I, _____, hereby give my counselor,
(client's name)

_____, in cooperation with Christian Counseling Services, consent to record counseling sessions through electronic or other means. These recordings will be used to aid the counseling process with supervisors, faculty, peers, interns, or others within the Christian Counseling Services training environment. The recordings will aid further understanding of important aspects of counseling therapies and client treatment in keeping with the Christian Counseling Services policy on privacy and confidentiality.

The recordings will not be included as part of the official client file and will only be shared under the supervision of **Jennifer Cecil, M.Ed, LPC**. Recordings will be deleted with the completion of supervision and training.

_____ I acknowledge that I have discussed this procedure with my counselor and give my
(INITIAL) consent to record my counseling sessions for supervisory purposes.

_____ I give my permission for said recordings to be used for training purposes as described
(INITIAL) within the contents of this consent form.

I understand that refusal to sign this form will <u>not</u> affect my eligibility for receiving services at this agency.

Signed: _____ Date: _____

For Minor (if applicable): _____
Relationship (circle one): Mother Father Guardian

Counselor: _____ Date: _____

Christian Counseling SERVICES

CONSENT FOR TELEHEALTH CONSULTATION:

Telehealth is any electronic means of communicating with my therapist, including phone calls, text messages, emails, and video-conferencing. Telehealth is utilized with any communication that is not considered administrative in nature (i.e. scheduling, office location, paperwork, etc.).

1. I understand that my provider is able to offer telehealth consultation, including video services, when appropriate and with my expressed consent. I have the right to use and refuse these services for some or all of my therapy.
2. My therapist has explained to me how the video conferencing technology will impact my sessions and therapeutic care. I acknowledge that video sessions will not be the same as an in-person appointment, due to the fact that I will not be in the same room as my provider and that this implies a variety of limitations and differences related to indirect contact.
3. I understand that telehealth has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. In the case of a video session, I understand that I am responsible for ensuring that my location is private and quiet, so that the telehealth session can be completed effectively. I understand that I must provide details about my location (such as: the physical address, online map pin/link, or a visual of the room) and my identity (such as confirming details about myself against my record or giving a predetermined password) at the onset of a telehealth session. This is necessary to protect my confidentiality and ensure that the coverage of my provider's license extends to my location.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that provider or I can discontinue a telehealth appointment if it is felt that the Internet connections are not adequate for the situation or my confidentiality is compromised.
6. I understand that there are some legal and ethical limitations and considerations regarding telehealth sessions, including: risk assessment, technology competence, effectiveness of the therapeutic model, long-term sustainability, national emergencies, and more. My therapist has the right to refuse to offer telehealth sessions, in accordance with state and board statutes.
7. I understand that there are innate risks to my privacy and confidentiality associated with using any telehealth service, specifically video conferencing technology. In offering telehealth for my convenience, I acknowledge that my provider cannot be responsible for these risks, though they will do their best to maintain my confidentiality whenever possible
8. I understand that I have the right to request the use a safe word, if I feel that my situation warrants extra protection or if I am not confident that my confidentiality will be maintained during a telehealth session (for example: conducting a session with children or a spouse in another room who could interrupt). The safe word selected should be easy to insert into conversation, if the safety or privacy of either location is compromised. If a safe word is needed, it should be established with my provider before the start of a session.
9. If a scheduled telehealth session cannot be completed as planned (due to complications such as, but not limited to: technical difficulties, confidentiality issues, or client discomfort), I

understand that I MAY be responsible for a fee, in accordance with my provider's late cancellation policy. These instances are few and far between and should this problem arise, I will need to discuss the implications with my provider to determine whether a full/partial fee or waiver applies.

10. I acknowledge that telehealth is NOT an emergency/crisis service and in the event of an emergency, I will use a phone to call 911.
11. I acknowledge that the developers/administrators of the telehealth platform used for my sessions are not responsible for the delivery of any healthcare, medical advice, or care.
12. I do not assume that my provider has access to any or all of the technical information related the use of a telehealth service. Specifically, I will not rely on my therapist to provide technical support for using a video platform. If a technical issue arises, a reasonable amount of time can be spent trying to resolve the problem, so that the session can be completed. However, if the issues are not resolvable after 10 minutes, the session may need to be rescheduled or moved to a different telehealth platform. If we get unexpectedly disconnected and cannot rejoin the conference room, I can contact my provider via text, phone call, or email to discuss an alternate platform and/or rescheduling.
13. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. My session will also not be recorded by my therapist without my consent.

I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this service and respective policies. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me, in a language in which I understand.

By signing this form, I certify:

· That I have read or had this form read and/or had this form explained to me.

· That I fully understand its contents including the risks and benefits of the procedure(s).

· That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature _____

Printed Name _____ Date _____