TEEN INTAKE FORM-PARENT

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Child's Name:_____ Today's Date:_____

Child's age:_____ Date of Birth (DOB):_____

Address:_____

_____

Parent's Name: _____ Parent's Name: _____

Primary Phone: _____ Home / Work / Cell (circle one)

Permission to leave voicemail? Yes / No Permission to text? Yes / No

Secondary Phone: _____ Home / Work / Cell (circle one)

Permission to leave voicemail? Yes / No Permission to text? Yes / No

Email: _____

Permission to email*? Yes / No

*Note: we cannot guarantee the confidentiality of email.

Who referred your child to Renovation Counseling? Please provide agency/professional's name & tel #:

_____

May I contact the agency/person to thank them for referring you? Yes No Please initial:_____

What is the main reason(s) you are seeking help for your child? (Include how long he/she's had these symptoms or problems):

_____

_____

_____

What are your hopes regarding your child's therapy?_____

_____

_____

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems? _____

_____

_____

Has your child ever been treated for any of the following? If so please circle and describe:

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Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions:

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

Please list your child's current prescription medications with dosage (psychiatric and general health):

Please list any previous psychiatric medications (with dosage and dates):

Do you suspect or know your child drinks alcohol or uses recreational drugs? If so, what kind & how often?

Do you or anyone close to your child consider his/her use to be a problem? Yes No

Do you suspect your child to be sexually active? Yes No If so, since when

Who is your child's primary care physician?

Who is your child's psychiatrist (if applicable)?

When was your child's last complete physical exam (mo/year)?

How many times a week does your child exercise? What type & how many minutes?

What types of food does he/she often eat?

YOUR CHILD'S FAMILY

	BIOLOGICAL MOTHER	BIOLOGICAL FATHER

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Current age, or if deceased, date, age, & cause of death		
Country of Origin		
Occupation		
Religious/Spiritual Affiliation (if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? _____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:__

_____

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

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FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

School name: _____ Public or Private (circle one)?

Street Address: _____

School District/County? _____ Phone: (_____) _____

Is your child in a regular classroom? Yes No Does your child have an IEP ? Yes No

Has your child ever received tutoring? Yes No If so, please explain: _____

What are your child's typical grades? _____

What are your child's strongest and weakest points academically? _____

_____

Are you satisfied with your child's educational program? Yes No Please explain: _____

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Home/Family Life

What are 5 things that you enjoy most about your teen? _____

_____

_____

_____

What are some activities you engage in as a family? _____

Does your child participate in any religious or faith based group? _____

What are your discipline techniques? _____

_____

_____

What are your strengths personally and as a parent? _____

What are some of your areas of needed growth? _____

What are your child's strengths (things he/she is good at)? _____

What are your child's areas of needed growth? _____

Social and Community Engagement

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activities is he/she involved? _____

How does your teen get along with other teens? _____

Who are some of your teen's closest friends (first name) _____

_____

Do you suspect that your child is bullied in person or on the internet?

Media Use

Do you have any concerns about your child's online or social media use (Facebook, Snapchat, Twitter, Instagram, texting, etc)? _____

How much time does your child spend online or on social media daily (Facebook, Snapchat, Twitter, Instagram, texting, etc)

Does your child have their own cell phone/tablet/computer? _____

Do you suspect your child regularly views pornography? How many hrs/week? _____

Your Child's Symptoms or Problems

How much are each of the following areas currently a problem for your child?

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	Not at all	A little	Somewhat	Considerably	Terribly
	1	**2**	**3**	**4**	**5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? Yes No
(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No

If yes, please describe:_____

_____

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: _____

_____

_____

_____

_____

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Therapy Agreement and Informed Consent

Please initial where indicated.

I have read and have had explained to me the following materials pertaining to therapy. My therapist has offered me the following or I viewed it online:

_____ Privacy Notice (HIPAA)

I believe I understand the basic goals, ideas, and methods of this therapy. I have no important questions or concerns that the therapist has not discussed with me. I understand that reaching the agreed upon therapy goal is not guaranteed. I further understand that the initial symptoms or problems that were presented to the therapist may initially become more intense.

With enough knowledge, and without being forced, I enter into therapy with this therapist. I will keep my therapist fully informed about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur and to work through them in my long-term interest. Our goals may have changed in nature, order of importance, or definition.

Cancellation Policy

I understand I am welcome to come to any part of my scheduled session, even if I have to be late. If I am running late, I will call my therapist to let him/her know. If I need to cancel or reschedule an appointment, I will give my therapist at least 24 hour's notice to avoid a cancellation fee.

_____I understand that cancelling a session with less than a 24-hour notice will result in a cancellation fee of $50.

_____ I understand failure to attend a session without giving notice (no show) will result in a cancellation fee equivalent to the full session fee.

_____I understand that after the first instance of a late cancellation or failure to attend a session, I will be required to keep an active credit card on file.

Payment Policy

Renovation Counseling is a self-pay counseling center, which allows clients to be seen without the involvement of an insurance company. By paying without insurance, you protect your privacy, avoid being given an insurance-mandated diagnosis in order to receive counseling services, and are more in control of the services you receive.

_____ I understand I may be able to receive reimbursement through my insurance provider's out-of-network benefits, flexible spending account (FSA), or health savings account (HSA). If I choose to do so, Renovation Counseling can provide me with an itemized receipt of services. I understand that if I wish to use any of these health benefits, it is my responsibility to verify coverage and submit any invoices for reimbursement. **I understand that, even if I use out-of-network, FSA, or HSA benefits, I am responsible to pay for my session in full at the time of service, or I may prepay for sessions.**

Fees

- $80 per 50-minute session before 4 pm
- $90 per 50-minute session 4 pm or later

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- $120 per 80-minute session before 4 pm
- $135 per 80-minute session 4 pm or later
- $160 per 105-minute session before 4 pm
- $180 per 105/minute session 4 pm of later

_____ I understand that Renovation Counseling may increase the cost per session, but that I will be notified at least 30 days in advance of any rate increase.

Cell phone/Email/Fax Communication

If I choose to use email or a cell phone for communication, I understand it may compromise the confidentiality of my information in ways my therapist cannot control. I also understand my therapist may share a printer with other therapists and that those therapists will work together to ensure my privacy to the best of their ability.

_____ I understand the security of client information is not guaranteed when information is left on a voicemail, texted or emailed.

Case Consultation

_____ I give permission to this therapist to present my case in consultation with other professionals or consultants and Renovation Counseling therapists, who are bound by the legal framework of privacy and confidentiality, for professional development and guidance purposes. I understand that this agreement will become part of my record of therapy.

Supervision

_____ I understand that my therapist is in the process of licensure and, as such, is required to receive supervision for his/her work. I grant permission for my therapist to discuss my sessions with his/her supervisor as a condition of my treatment.

Emergency Procedure

In the event of a life-threatening emergency, I should call 911. If I have another crisis that cannot wait I am aware I can call the Crisis Connection at 612-379-6363. If I have a crisis plan with my therapist, I will follow that first.

Inactive Records

Your complete record will be retained for seven years after you have completed treatment. At the end of seven years, the record will be entirely destroyed, leaving only the name of the client and date of record destruction. The time period begins from the date of the last visit (or for minors from the date they reach 18). Should there be any further direct client contacts the counting period will begin again at the date of new service.

Confidentiality Statement

Under the rules governing Marriage and Family Therapists in the state of Minnesota, a therapist, and employees and professional associates of the therapist, must not disclose any private information that the therapist, employee, or associate may have acquired in rendering services except as follows.

- When the Board of Marriage and Family Therapy is reviewing a therapist. The Board shall be allowed access to records of a client treated by a therapist under review if the client signs a written consent permitting access. If no consent form has been signed, the hospital, clinic, or licensee shall first delete data

in the record that identifies the client before providing it to the board.

- When disclosure is required by state law like prenatal exposure to drugs and alcohol, reports of child abuse and neglect and vulnerable adults abuse and neglect.

- When failure to disclose the information presents a clear and present danger to the health or safety of an individual.

- When the person, employee, or associate is a defendant in a civil, criminal, or disciplinary action arising from the therapy.

- When the patient is a defendant in a criminal proceeding and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses in that person's behalf.

- When a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving therapy, each such family member agrees to the waiver. Absent a waiver from each family member, a marital and family therapist cannot disclose information received by a family member.

All other private information must be disclosed only with the informed consent of the client.

Minnesota Mental Health Bill of Rights

- Expect that a therapist has met the minimal qualifications of training and experience required by state law.

- Examine public records maintained by the Board of Marriage and Family Therapy, which contain the credentials of the therapist.

- You may file a complaint with the Office of Mental Health Practice, 2829 University Avenue SE, Suite 340, Minneapolis, MN 55414-3239. Their phone numbers are (612) 617-2105; TTY: (800) 627-3529; and fax: (612) 617-2103.

- You, the client, are billed directly for services, or your insurance coverage may be billed with your permission.

- You have a right to reasonable notice of changes in services or charges.

- You have the right to receive a summary, in plain language, of the theoretical approach used by us in working with clients.

- You have the right to complete and current information concerning our assessment and recommended course of treatment, including the expected duration of treatment.

- You have the right to expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner working with you;

- Your records and transactions with us are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law.

- You have the right to be allowed access to records and written information from records in accordance with Minnesota statutes.

- You should know that other services may be available in the community. To find out about such services, you may call First Call for Help at 651-291-0211.

- You have the right to choose freely among available practitioners, and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.

- You have a right to coordinated transfer when there is a change in the provider of services.

- You may refuse services or treatment, unless otherwise provided by law.

- You may assert these and other rights without retaliation.

My signature on this Therapy Agreement and Informed Consent indicates that I:

- **Have reviewed, understand, and consent to the policies and information above, and**

- **Consent for my child to participate in therapy at Renovation Counseling**

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

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