

**Adolescent Intake Form  
Parent's Form**

Date \_\_\_\_\_

Referral Source \_\_\_\_\_

Parent/Legal Guardian's Name \_\_\_\_\_

Child's Name \_\_\_\_\_  
Last First Middle  
Age \_\_\_\_\_  
Last First Middle

Child's Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_  
Street City/State Zip Code

Home Phone \_\_\_\_\_ Permission to leave message? Yes \_\_\_ No \_\_\_

Mobil/Pager \_\_\_\_\_ Permission to leave message? Yes \_\_\_ No \_\_\_

Emergency Contact \_\_\_\_\_  
Name Address Phone #

Mom's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Dad's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Permission to contact at work? Mom: Yes \_\_\_ No \_\_\_ Dad: Yes \_\_\_ No \_\_\_

Social Security # Mom \_\_\_\_\_ Dad \_\_\_\_\_

Mother's Marital Status Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Remarried \_\_\_  
Never Married \_\_\_

Father's Marital Status Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Remarried \_\_\_  
Never Married \_\_\_

If the child's biological parents are divorced, how long was the marriage? \_\_\_\_\_

How long have they been divorced? \_\_\_\_\_

Is child adopted? Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_

Custody arrangement Mother \_\_\_ Father \_\_\_ Grandparent(s) \_\_\_

If other, please specify \_\_\_\_\_

People currently living in the household:

Name	Relationship to client	Age	Education level	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Immediate family members living elsewhere:

Name	Relationship to client	Age	Education level	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Would you be willing to be a part of your child's therapy? Mom Yes \_\_\_ No \_\_\_  
Dad Yes \_\_\_ No \_\_\_

Has your child ever been hospitalized? If Yes please give dates and reasons \_\_\_\_\_

Has your child been evaluated for psychiatric treatment? If yes please indicate the Psychiatrist's name \_\_\_\_\_

Is your child taking any medication? If Yes please list \_\_\_\_\_

Your child's PCP name. \_\_\_\_\_

Has your child ever been seen by another counselor/psychologist? Yes \_\_\_ No \_\_\_

If yes, who? \_\_\_\_\_ For how long? \_\_\_\_\_

What concerns do you have about your child? \_\_\_\_\_

How long have these concerns existed? \_\_\_\_\_

Have others expressed concerns about your child? \_\_\_\_\_

What do you think might be causing this? \_\_\_\_\_

How have you tried to address your concerns? \_\_\_\_\_

Describe your child's personality \_\_\_\_\_

Does your child have friends or activities that you don't approve of? If yes, please explain.

Describe your relationship with your child \_\_\_\_\_

Any history of psychiatric illness in your family? If yes, please explain \_\_\_\_\_

Any history of physical, emotional, or sexual abuse in your family? \_\_\_\_\_

Any history of alcohol or drug abuse in your family? \_\_\_\_\_

What community resources, if any, are members of your family using? (twelve step program, WIC, Hope's Door, City House, etc.) \_\_\_\_\_

Any additional comments or concerns \_\_\_\_\_

## Child Behavioral Checklist

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Form completed by \_\_\_\_\_

### Problem Behaviors

Please indicate the severity of these problem behaviors if you have seen or experienced them in your child in the past three months.

0 -- Not at all    1 -- Rarely    2 -- Sometimes    3 -- Often    4 -- Most of the time    5 -- All of the time

- \_\_\_\_\_ Feels sad or depressed
- \_\_\_\_\_ Feels anxious or nervous
- \_\_\_\_\_ Problems with eating (lack of appetite, overeating)
- \_\_\_\_\_ Excessive preoccupation with video game/movie characters
- \_\_\_\_\_ Arguing with others (peers, teachers, parents, authority figures)
- \_\_\_\_\_ Hurting animals
- \_\_\_\_\_ Problems with sleep (going to sleep, sleeping all night, too much sleep, refusal to sleep alone)
- \_\_\_\_\_ Nightmares
- \_\_\_\_\_ Excessive energy or difficulty being still
- \_\_\_\_\_ Bedwetting
- \_\_\_\_\_ Says that people, family, etc. would be better without him/her
- \_\_\_\_\_ Sets fires
- \_\_\_\_\_ Violent outbursts (throwing, breaking, or destroying objects)
- \_\_\_\_\_ Self destructive behavior (cutting or scratching him/herself)
- \_\_\_\_\_ Getting into verbal or physical fights
- \_\_\_\_\_ Talks of death
- \_\_\_\_\_ Running away or threats of running away
- \_\_\_\_\_ Urination or bowel movements in pants during the day
- \_\_\_\_\_ Bullying or being bullied
- \_\_\_\_\_ Verbal attacks on others
- \_\_\_\_\_ Worries that something bad is going to happen
- \_\_\_\_\_ Lies
- \_\_\_\_\_ Breaking rules (Sitting in desk at school, bed time, etc.)
- \_\_\_\_\_ Lonely or complains of not having friends
- \_\_\_\_\_ Unrealistic fears (using public bath rooms, ghosts, blood, being abandoned, etc.)

### Functioning Levels

Rate the level of functioning you have observed in your child in the following areas.

0 – Extreme trouble    1 – Quite a few troubles    2 – Some troubles    3 – Fair    4 – Doing very well

- \_\_\_\_\_ Expresses emotions appropriately
- \_\_\_\_\_ Is motivated and finishes projects and assignments
- \_\_\_\_\_ Completes household chores and responsibilities
- \_\_\_\_\_ Attends school and is making passing grades
- \_\_\_\_\_ Thinks clearly and makes good choices
- \_\_\_\_\_ Gets along well with family
- \_\_\_\_\_ Gets along well with friends
- \_\_\_\_\_ Is able to concentrate, pay attention, and follow through on tasks
- \_\_\_\_\_ Participates in recreational activities with peers
- \_\_\_\_\_ Accepts limitations and responds appropriately when told "no"
- \_\_\_\_\_ Does things independently without supervision
- \_\_\_\_\_ Positive self-esteem

## Consent to Treatment

I, Kim Ferren, am committed to providing high quality services to my clients and to providing them with all of the information necessary to be informed about the treatment process. As part of my effort in this regard, I am providing the following information about legal and ethical issues. If you agree to these stipulations, please sign the last page of this form. Please feel free to discuss this with Kim Ferren before signing the consent.

1. **Confidentiality:** I am committed to confidentiality to the fullest extent by Texas law. There are several exceptions, the following are common: 1) Any evidence of child abuse (past or present) must be reported. 2) If an individual intends to take harmful, dangerous, or criminal actions against another human being or against him/herself, it is my duty to report such action or intent to authorities. 3) Sexual improprieties by a former therapist are a criminal offense and must be reported. (You have certain rights in such reporting which your therapist can explain to you.) 4) Certain court orders/actions such as custody cases, malpractice actions, criminal cases, etc. 5) Collection of fees: If you have questions about this area, please feel free to discuss it with me.
2. **Fees and insurance:** My standard fee is \$150.00 for the initial visit and \$125.00 per 45-50-minute session. Some insurance companies may cover part of this cost. If you have coverage, you are welcome to assign the benefits and pay only your co-pay portion at the time of each visit. If your policy deductible has not been met, you are responsible for paying that amount. **By law, I am not allowed to waive deductible or co-payments.**

By consenting to treatment, you acknowledge that you are responsible for the cost of these provided services (to you or your minor child) and agree to pay them when billed or at the time of services. If services are not paid, then you agree to pay a service charge within 30 days notice. After 60 days the account may be assigned to an outside agency, in which case you will be responsible for paying attorney fees and/or collection fees and expenses.

It is important to remember that if you choose to utilize your insurance, I will be obligated to provide them certain information about your case including (but not necessarily limited to) a diagnosis, type and dates of service. By assigning benefits to me (Kim Ferren) you are authorizing me to provide your insurance carrier (or their intermediary) whatever information is necessary to process the claim. If you choose to utilize your insurance, it may affect your insurability. If at any time you have questions about the fees or insurance, please feel free to discuss it with me.

3. **Appointments:** If you need to cancel an appointment, 24-hours notice is required. If you miss an appointment without sufficient notification, you will be charged. Missed appointments CANNOT be filed with insurance. Therefore, you are responsible for ½ the entire fee.
4. **Right to withdraw from treatment.** If a conflict arises for the client or the therapist, either has the right to withdraw from the treatment process. If the therapist feels the need to withdraw from providing treatment, he/she will so inform the client and provide appropriate referrals.
5. If legal actions occur in which I am requested or subpoenaed to provide testimony (such as in a custody case) you will be responsible to provide the following even if the subpoena is sent from the opposing side of the case: 1) travel expenses, 2) hourly or per diem fees based on my existing fees, from the time I leave the office until I return. At

least 50% of the anticipated cost will be expected prior to the court appearance. Record copying fees begin at \$25.00.

6. In the unlikely event that I, in my clinical judgment, believe you to be dangerous to yourself or someone else, by signing the consent you authorize me to contact either the persons listed as your emergency contacts, or someone else to provide assistance through the crisis situation.
7. The services I provide as a therapist will include an assessment phase, a treatment phase, and a termination phase as part of the process of clinical psychotherapy. Ours will be a strictly professional relationship with clear professional boundaries.
8. In an emergency situation, you are encouraged to call 911, go to your nearest emergency room, or call the Suicide and Crisis Center at any time at 214/828-1000. Non-emergency phone calls to my office will be returned by the following business day.

***If you have read and understand these aspects of consent, please sign below. Feel free to take a copy of the consent if you wish. If you have questions about any of the information on this form, discuss them with me and wait to sign the form with me. I am looking forward to working with you.***

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Signature

Date

ANY PROBLEMS REGARDING ETHICAL QUESTIONS AND/OR CONCERNS MAY BE DIRECTED TO THE FOLLOWING CONSUMER HOTLINE: 1-800-942-5540

**Kim Ferren, LPC**  
**2850 Shoreline Trail Suite 102**  
**Rockwall, Texas 75032**  
**(972) 679-1622, Fax # (972) 722-7736**

Notice of Privacy Practices-HIPPA

This document contains important summary information about the Health Insurance Portability and Accountability Act (HIPPA), a new federal law that provides new privacy protections and new patient rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA 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 HIPPA and its application to your personal health information in greater detail. This notice is posted in the lobby for your convenience. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session.

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Name

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Date