Family Resource Center
OF NORTHEAST GEORGIA
Thriving Families. Nurtured Children.

Child/Adolescent INTAKE INFORMATION

This Form is Confidential

Today's Date: _____

Child's Name: _____
Last First Middle Initial

Age: _____ Date of birth: _____ Gender: _____

Grade: _____ School: _____

Name of person completing this form: _____

Your relationship to child: _____

Best contact phone # for you: _____ Indicate: ____ Cell ____Home ____Work

May we contact you at this #? ____ Yes ____No If cell, may we text? ____ Yes ____ No

Calls will be discreet, but please indicate any restrictions: _____

Email: _____ Can we email you at this address? ____ Yes ____No

Parent or Legal Guardian's Name: _____
Last First Middle Initial

Home street address: _____

City: _____ State: _____ Zip: _____

Phone # if different than yours: _____

Occupation: _____ Employer: _____

With whom does child live? _____

Their relationship to child? _____

Person(s) to notify in case of any emergency: _____ Phone # _____

Relationship to child: _____

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so:

(**Your Signature**): _____

Is child in foster care? ____ Yes ____ No If yes, for how long? _____

If adopted, does child know of adoption? ____Yes ____ No What age was your child at the time of adoption? _____

Please check all that apply to your child and CIRCLE the main problem:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			Tantrums →			Nausea →		
Depression			Parents Divorced			Stomachaches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic Attacks			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues Re: Divorce			Sweating		
Memory Problems			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Social Isolation		
Communicating with Others			Acts of Violence/ Feelings of Hostility			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self/Others			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Strange Thoughts/Behaviors		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

- ☐ Drug/Alcohol Problems
- ☐ Legal Trouble
- ☐ Domestic Violence
- ☐ Suicide
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Hyperactivity
- ☐ Learning Disabilities
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric Hospitalization
- ☐ "Nervous Breakdown"

Social Support, Self-Care and Education:

Child's current level of satisfaction with friends and social support: **Poor** 1 2 3 4 5 6 7 **Excellent**

How would you describe your child's relationships with his/her peers?

_____

_____

Please briefly describe any history of abuse, neglect and/or trauma:

_____

_____

_____

Please briefly describe your child's self-care and coping skills:

_____

_____

What are your child's diet, weight, and exercise/activity patterns?

_____

_____

Please briefly describe your child's school performance and experience:

_____

_____

_____

What are your child's hobbies, talents, and strengths?

_____

_____

History of Concern

Please describe what concerns you have regarding your child:

_____

_____

Have there been any previous incidents of the current concern? If yes, please describe:

_____

_____

How long has the concern existed?

_____

_____

Have there been any significant stressors or change for the family: losses, births, deaths, moves, hospitalizations, financial problems, recently or in the last several years?

_____

_____

What attempts have been made to resolve the concerns?

_____

_____

Legal or custody concerns:

_____

_____

What are your/your child's goals for therapy?

_____

_____

Have you discussed these goals with child?

_____

_____

Sexual and Gender Identity: ____ Heterosexual ____ Lesbian ____ Gay ____ Bisexual
____ Transgender ____ Asexual ____ In Question ____ Other

Racial/Ethnic Identity:

____African/African-American/Black ____ Bi-Racial/Multi-Racial ____ White/European-American
____American Indian/Alaska Native ____ Latino/Latino-American ____ Not Listed
____Asian/Asian-American/Asian Pacific Islander ____ Middle Eastern/Middle Eastern-American

Child's Medical History

Please explain any significant medical problems, symptoms, or illnesses your child has had:

_____

_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons):

_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):

_____

_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons):

_____

_____

Family Dynamics

How would you describe your child's relationship with his or her mother?

_____

_____

How would you describe your child's relationship with his or her father?

_____

_____

Are the child's parents still married or did they divorce? _____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her?

_____

_____

Please describe your child's relationships with his/her grandparents:

_____

_____

_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life:

_____

_____

_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?

_____

_____

_____

Current living situation: (Who lives in the home currently?)

_____

_____

Family History

FAMIY PSYCHIATRIC HISTORY/**PARENTS**: Please Indicate: F/Father, M/Mother, O/Other

____ADD/ADHD	____Alcoholism	____Psychosis
____Antisocial Features	____Depression	____Schizophrenia
____Anxiety	____Domestic Abuse	____Sleep Disturbance
____Bipolar	____Panic Disorder	____Substance Abuse
____Bereavement	____Phobic Disorder	____Suicide/Attempts
____Conduct Disorder/Disruptive	____PTSD	____Treatment/Inpatient

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements.)

_____

_____

_____

Is ex-spouse (biological parent) aware that you are bringing their children to counseling? ____Yes ____No

If not, please explain:

_____

_____

_____

Name of person who referred you to the Family Resource Center_____

Agency: _____

Please provide information of agencies your family is involved with:	
Agency	**Caseworker Name & Contact Information**
Law Enforcement	
DFCS	
Guardian Ad Litem	
Attorney	
Other:	
Other:	

Acknowledgement of Receipt of Information

By initialing and signing below you agree to all the terms set forth by the Family Resource Center-Prevent Child Abuse Habersham Counseling Program.

_____ Please initial here if you have read the policies on appointment cancellations and the procedures for contacting your therapist in the Welcome Packet (pg. 1).
_____ Please initial if you have been informed on the location of the HIPPA Notice of Privacy Practices at the Family Resource Center Annex (pg. 4). You may request a copy
_____ Please initial here if you have read the emergency services phone numbers in the Welcome Packet (pg. 2).

CONSENT TO RECEIVE SERVICES

I, _____, hereby consent and give permission to the Family Resource Center to provide counseling services to me and/or my child and I agree to abide by all policies, instructions, and rules set forth by the Family Resource Center. I further agree not to subpoena: (a) any records relating to the services I or my child receives from the Family Resource Center, or (b) the testimony of any therapist or other person employed or affiliated with the Family Resource Center.

To the extent that a court orders a therapist or other Family Resource Center Staff member to appear in court notwithstanding this agreement, all associated time will be billed to the person who issued the subpoena or caused it to be issued at a rate of $400.00 per hour.

The rate of $400.00 per hour will be charged for all activities related to the subpoena, including but not limited to communicating with lawyers or the guardian ad litem, traveling to/from the courthouse, waiting at the courthouse, and reviewing notes.

Date: _____

_____

Signature of Client, Parent, Guardian, or Personal Representative

_____

Printed Name

NOTE: If you are signing as a personal representative of an individual, please describe below your authority to act for this individual (parent, guardian, power of attorney, healthcare surrogate, etc.).

_____

_____

PARENT AGREEMENT FOR CHILD COUNSELING SERVICES

I, _____, recognize that the Family Resource Center has agreed to provide counseling services to my child free of charge in exchange for my agreement to each of the following:

1. I will provide to the Family Resource Center a copy of the current standing order and/or any applicable parenting agreement (signed by both parents and the judge) that demonstrates the custodial rights of each parent at the first intake session. I will notify the Family Resource Center and my child's therapist of any changes made to the standing order and/or parenting agreement immediately, and I will provide a copy of the new standing order and/or parenting agreement before the child's next session.

2. I understand that the Family Resource Center generally requires signed consent from all legal guardians before a child begins counseling. In certain circumstances, however, a therapist may meet with a child with the consent of one guardian.

3. I understand that the child's therapist may discuss the child's counseling sessions only to a court-ordered Guardian ad Litem (GAL) and/or custody evaluator (CE) whom the court has appointed. In appropriate circumstances, the child's therapist may also communicate with the child's personal representative for HIPAA purposes. A child's healthcare records will be made available only as required by law, and by consenting for my child to receive services from the Family Resource Center, I am hereby waiving my right to request such records for litigation purposes. I agree that my child shall have a confidential relationship with his or her therapist.

4. I understand that in circumstances in which a child's therapist is required to provide information to a GAL, CE, or personal representative, the therapist's time will be billed to and paid by me at the hourly rate set by the Family Resource Center for court-related activities.

5. I understand that the Family Resource Center and my child's therapist will be in equal contact with both parents who share in the legal custody of the child being seen for counseling. Further, I agree to assist in my child's treatment by participating in consultations and/or family sessions, along with the others in my household, to the extent recommended by my child's therapist. I further agree to behave respectfully towards all persons involved in such sessions.

6. I agree not to subpoena: (a) any records from the Family Resource Center or my child's therapist, or (b) the testimony of my child's therapist or any other person employed or affiliated with the Family Resource Center. **I recognize that by signing this agreement, I am agreeing not to use court process to obtain records or information relating to my child's therapy.** I understand that this agreement is critical to my child's well-being and ability to trust his or her therapist.

_____ _____

Signature of Child's Parent/Legal Guardian *Date*