Indigo Counseling Center

Child and Adolescent Intake Forms

How Did You Hear About Indigo Counseling Center?_____

Client's name: _____ Date: __/__/____

Gender: _____ Date of birth: __/__/___ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

Emergency contact name:_____Phone: _____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

____ Anger management ____ Anxiety ____ Coping ____ Depression

____ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

____ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs ____ Hyperactivity

____ Other mental health concerns (specify): _____

_____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ___ Yes ____ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? _____ Yes ____ No

If Yes, describe: _____

Please complete the following section for each Parent

Parent Name: _____ Age: ____ Occupation: _____

Where employed: _____ ___FT __ PT Work phone: _____

Parent's education: _____

Is the child currently living with this parent? _____ Yes _____ No

__ Natural parent __ Step-parent __Adoptive parent ___Foster home ____ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with this parent?

____ Yes __ No If Yes, please explain: _____

_____

How is the child disciplined by this parent? _____

For what reasons is the child disciplined by this parent? _____

Parent Name: _____ Age: ___ Occupation: _____

Where employed: _____ ___FT __ PT Work phone: _____

Parent's education: _____

Is the child currently living with this parent? _____ Yes _____ No

__ Natural parent __ Step-parent __Adoptive parent ___Foster home ____ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with this parent?

____ Yes __ No If Yes, please explain: _____

_____

How is the child disciplined by this parent? _____

For what reasons is the child disciplined by this parent? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	___F ___M	___home ___away	___poor ___average ___good
_____	___	___F ___M	___home ___away	___poor ___average ___good
_____	___	___F ___M	___home ___away	___poor ___average ___good
_____	___	___F ___M	___home ___away	___poor ___average ___good
Others living in the household			Relationship (e.g., cousin, foster child)	
_____	___	___F ___M	_____	___poor ___average ___good
_____	___	___F ___M	_____	___poor ___average ___good
_____	___	___F ___M	_____	___poor ___average ___good
_____	___	___F ___M	_____	___poor ___average ___good

Comments: _____

_____

_____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

___ Allergies	___ Deafness	___ Muscular Dystrophy
___ Anemia	___ Diabetes	___ Nervousness
___ Asthma	___ Glandular problems	___ Perceptual motor disorder
___ Bleeding tendency	___ Heart diseases	___ Mental Retardation
___ Blindness	___ High blood pressure	___ Seizures
___ Cancer	___ Kidney disease	___ Spinal Bifida
___ Cerebral Palsy	___ Mental illness	___ Suicide
___ Cleft lips	___ Migraines	___ Other (specify): _____
___ Cleft palate	___ Multiple sclerosis	_____

Comments re: Family Health: _____

_____

Childhood/Adolescent History

Pregnancy/Birth

Was the pregnancy with child planned? ___ Yes ____ No Length of pregnancy: _____

Mother's age at child's birth: _____ Other Parent/Father's age at child's birth: _____

Child was number ___ of _____ total children.

While pregnant did the mother smoke? ___ Yes __ No If Yes, what amount: _____

Did the mother use drugs of alcohol? ___ Yes __ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)

__ Yes ____ No

If Yes, describe: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Infancy/Toddlerhood Check all which apply:

___ Breast fed	___ Milk allergies	___ Vomiting	___ Diarrhea
___ Bottle fed	___ Rashes	___ Colic	___ Constipation
___ Not cuddly	___ Cried often	___ Rarely cried	___ Overactive
___ Resisted solid food	___ Trouble sleeping	___ Irritable when awakened	___ Lethargic

Developmental History Please note the approximate age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: ___ slow ___ average ___ fast

Age for following occurrences (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ___ Yes ____ No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to your child are spiritual matters? ___ Not __ Little _____ Moderate __ Much

Is your child affiliated with a spiritual or religious group? _____ Yes _____ No

If Yes, describe: _____

Is your family affiliated with a spiritual or religious group? ___ Yes _____No

If Yes, describe: _____

Would your child like your spiritual/religious beliefs incorporated into the counseling? _____ Yes ____ No

If Yes, describe: _____

Education

Current school: _____ School phone number: _____

Type of school: ____ Public ____ Private ___ Home schooled __ Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? ____ Yes ___ No If Yes, describe: _____

In gifted program? ___ Yes ____ No If Yes, describe: _____

Has child ever been held back in school? ____ Yes ____ No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? ___ Yes ____ No

If Yes, describe: _____

Has the child been tested psychologically? ____ Yes __ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

____ Anxious ____ Passive ____ Enthusiastic ____ Fearful

____ Eager ____ No expression ____ Bored ____ Rebellious

____ Other (describe): _____

Approach to School Work:

____ Organized ____ Industrious ____ Responsible ____ Interested

____ Self-directed ____ No initiative ____ Refuses ____ Does only what is expected

____ Sloppy ____ Disorganized ____ Cooperative ____ Doesn't complete assignments

____ Other (describe): _____

Performance in School (Parent's Opinion):

____ Satisfactory ____ Underachiever ____ Overachiever

____ Other (describe): _____

Child's Peer Relationships:

____ Spontaneous ____ Follower ____ Leader ____ Difficulty making friends

____ Makes friends easily ____ Long-time friends ___ Shares easily

____ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ____ Mother ____ Father ____ Shared ____ Other (specify): _____

Health: ____ Mother ____ Father ____ Shared ____ Other (specify): _____

Problem behavior: ____ Mother ____ Father ____ Shared ____ Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ____ Poor __ Average ____ Good ____ Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? ___ Lower ___ Same ___ Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

___ Abortion	___ Hay-fever	___ Pneumonia
___ Asthma	___ Heart trouble	___ Polio
___ Blackouts	___ Hepatitis	___ Pregnancy
___ Bronchitis	___ Hives	___ Rheumatic Fever
___ Cerebral Palsy	___ Influenza	___ Scarlet Fever
___ Chicken Pox	___ Lead poisoning	___ Seizures
___ Congenital problems	___ Measles	___ Severe colds
___ Croup	___ Meningitis	___ Severe head injury
___ Diabetes	___ Miscarriage	___ Sexually transmitted disease
___ Diphtheria	___ Multiple sclerosis	___ Thyroid disorders
___ Dizziness	___ Mumps	___ Vision problems
___ Ear aches	___ Muscular Dystrophy	___ Wearing glasses
___ Ear infections	___ Nose bleeds	___ Whooping cough
___ Eczema	___ Other skin rashes	___ Other
___ Encephalitis	___ Paralysis	_____
___ Fevers	___ Pleurisy	

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Please check if there have been any recent changes in the following:

___ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level

___ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Most recent examinations	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last vision exam	_____	_____	_____

Last hearing exam _____ _____ _____

Most recent surgery _____ _____ _____
Other surgery _____ _____ _____
Upcoming surgery _____ _____ _____

Family history of medical problems: _____

Medications

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Allergic to any medications or drugs? ___ Yes ___ No
If Yes, describe: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	___ No __ Low ___ Med ___ High
Lunch	____ / week	_____	___ No __ Low ___ Med ___ High
Dinner	____ / week	_____	___ No __ Low ___ Med ___ High
Snacks	____ / week	_____	___ No __ Low ___ Med ___ High

Comments: _____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes __ No
If Yes, describe & complete information below: _____

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								

PCP/LSD/Mescaline	_____	_____	_____	_____	___	___	___	___
Inhalants	_____	_____	_____	_____	___	___	___	___
Caffeine	_____	_____	_____	_____	___	___	___	___
Nicotine	_____	_____	_____	_____	___	___	___	___
Over the counter	_____	_____	_____	_____	___	___	___	___
Prescription drugs	_____	_____	_____	_____	___	___	___	___
Other drugs	_____	_____	_____	_____	___	___	___	___

_____

Substance of preference

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

Substance Abuse Questions <u>to be answered by Child/Adolescent</u>

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

_____

Describe how your use has affected family or friends (include their perceptions of your use):

_____

_____

Reason(s) for use:

___ Addicted ___ Build confidence ___ Escape ___ Self-medication

___ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

___ Yes ___ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___ Yes ___ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

_____

Does your body temperature change when you drink? _____ Yes _____ No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job or school? _____ Yes ___ No

If Yes, describe: _____

Counseling/Prior Treatment History

*<u>Information about **child/adolescent** (past and present):</u>* _____

	Yes	No	When	Where	Child/Adolescent's reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____

Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

*Information about **family/significant others** (past and present):*

	Yes	No	When	Where	Child/Adolescent's reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

Behavioral/Emotional

Please check any of the following that are typical for your child:

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries excessively
___ Other:
_____
_____

Please describe any of the above (or other) concerns: _____

_____

How are your child's problematic behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Has the child/adolescent experienced death? (friends, family pets, other) ___ Yes ____ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

____ Yes ___ No If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist us in understanding current concerns or problems?

_____

_____

_____

What are your goals for the child's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

_____

For Staff Use

Therapist's comments: _____

_____

_____

Therapist's signature/credentials: _____ Date: ____/____/_____

Supervisor's comments: _____

_____

_____ Physical exam: _____ Required ____ Not required

Supervisor's signature/credentials: _____ Date: ____/____/_____

(Certifies case assignment, level of care and need for exam)

Important Signatures For Consent for Child/Teen Therapy:

As the parent, foster parent or legal guardian, I give consent for my child/teen to have therapy at Indigo Counseling Center.

_____ _____

Signature Date

If divorced, joint custody, and/or court required, I, the second parent also give consent for my child/teen to have therapy at Indigo Counseling Center.

_____ _____

Signature Date

Insurance Information: Please check with your insurance carrier regarding mental health coverage. Also, ask about your co-pay and deductible.

Primary Insurance:
Primary Insurance Carrier _____
Policy Holder_____Relationship to Client_____
ID#_____Group #_____
Co-Pay_____Deductible_____

Secondary Insurance:
Secondary Insurance Carrier _____
Policy Holder_____Relationship to Client_____
ID#_____Group #_____
Co-Pay_____Deductible_____

Insurance Billing: I authorize Indigo Counseling Center to release any medical information to my insurance company that may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Indigo Counseling Center. I understand that I am responsible for payment of services rendered by Indigo Counseling Center regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in non-payment by my insurance company. I agree to notify Indigo Counseling Center immediately whenever my insurance coverage changes.
Signature: _____Date:_____

Credit Card on File: Indigo Counseling requires a credit card on file. I hereby give my consent to charge my credit card for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier deems payable by me. **Cancellation Policy:** Indigo Counseling requires 24 hour cancellation notice. I hereby give consent to charge my credit card on file for missed ($100.00) or late cancel ($85.00) appointments.

Card Type: Visa____Master Card____American Express____Discover_____
Card Number_____Card Holder Name_____
Exp. Date_____ CVV Code_____Billing Zip Code_____
Card Holder Signature_____Date_____

Private Pay: All payments are due at beginning of each session. Private pay session amount is:
$_____ Signature_____

Fees

Intake Session: 90791, 50-55 minutes, $225.00
Individual Therapy: 90837, 53+ minutes, $175.00
Individual Therapy: 90834, 38-52 minutes $150.00
Couples/Family Therapy, 90847 53+ minutes $175.00
Group Therapy, 90853, 60+ minutes $55.00

Fees Not Billable to Insurance:
Late Cancel (less than 24-hour notice): $85.00
No Show: $100.00
Returned Check: $30.00
Phone Calls, Letters, Reports, Consultation: $43.75 per fifteen minutes/$175.00 per hour
Telephone Consultation: $43.75 per fifteen minutes/$175.00 per hour

Limits of Confidentiality:
Content of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:
--Duty to Warn and Protect: When a client discloses intentions to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

--Abuse of Children and Vulnerable Adults: If a client states or suggests he or she is abusing a child or vulnerable adult, the mental health professional is required to report this information to the appropriate authorities.

--Court Order: A court order, subpoena, or other legal process.

--Prenatal Exposure to Controlled Substances: Mental health care professionals are required to report prenatal exposure to controlled substances to the appropriate authorities.

--Insurance Providers (When applicable): Insurance providers and other third party payers are given information that they request regarding services to clients. Information that may be requested may be: types of services, dates/times of services, diagnosis, treatment plan, progress in therapy, case notes and summaries.

I have **read and understand** the **Limits of Confidentiality:**

Signature_____**Date**_____

CLIENT NOTICE OF PRIVACY PRACTICES: This notice describes how your health may be used and disclosed and how you are able to access this information. Please review it carefully. Protecting our client's privacy has always been important to this practice. A new federal and state law entitled the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At Indigo Counseling Center, we are very careful to keep your health information secure and confidential. This law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a physician specialist, with whom we may involve in your care plan. We may use or disclose your health information for payment for your services. For example, we may send a report of your progress to your health insurance company. We may disclose your health information for our normal healthcare operations. For example, one of our staff members will enter your information into our computer. We may share your medical information with our business associates, such as a billing representative or service. We have a written contract with each business associate which requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information to you. We may also want to call and remind you about appointments. If you are not home, we may leave this information on your answering service or with the person who answers the telephone unless you have instructed us otherwise. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will advise you if we are able to fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Supply us, in writing, your request to make changes. If you request to include a statement in your file, please submit it to us in writing. We reserve the right to make the changes or not, however, we will accommodate your request by including your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information. You have the right to receive a copy of this notice. If we change any details of this notice, we will notify you of the changes, in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington DC, 20201. If you believe that your privacy has been compromised or if you are seeking more assistance regarding your personal health information, we ask that you first contact Indigo Counseling Center, owner, Joan Hause at 612-293-5124.

I have **read and understand** the **HIPAA/Privacy Practices**:

Signature_____Date_____

Court and Legal Proceedings:
Indigo Counseling Center does NOT provide disability determination, custody studies or handle court issue. Indigo Counseling Providers do not perform court evaluation, nor do they appear in court on behalf of children, or adults. Indigo Counseling Center providers are not trained for, nor do they maintain records with the intended purpose of court involvement.

If we are forced to further document or respond to information requests, meet with your representative, or testify in court, our fees are $400.00 per hour, plus all expenses, half-day minimum, paid in advance.

Consultation and Supervision: To provide you with the best possible service, Indigo Counseling Center providers engage in ongoing supervision and consultation with other mental health professionals. When discussing clients in other forums, confidentiality is protected.

After Hours Emergencies: Indigo Counseling Center clinicians are not available for after-hour emergencies. Messages are checked week days from 9:00 to 5:00. For after hour emergencies, if you need immediate assistance, call 911 or these crisis phone numbers:
Crisis Connection: 612-379-6363
National Suicide Prevention Lifeline: 1-800-273-8255
Riverwind Crisis Services: 763-755-3801
Dakota County Crisis: 952-891-7171
Ramsey County Crisis: 651-266-2700
Hennepin County Crisis: 612-596-1223

I understand and agree to abide by the policies stated above.

Signature_____**Date**_____

Indigo Counseling Center

Teletherapy Policy and Consent

I hereby consent to engaging in online counseling services with the therapist I am working with at Indigo Counseling Center. Teletherapy services may be engaged in situations such as :

1. Weather that causes hazardous driving conditions.
2. Illness or medical treatment that makes it difficult for in-person sessions.
3. Loss of transportation or difficulty making it to in-person appointments.
4. Travel that causes consecutive weeks of missed appointments.

Patient Confidentiality, Privacy and Safety

Teletherapy is provided through a HIPAA compliant online service to protect client's privacy. The therapist will use a secure online service and will interact with client from a private location. The client will also be responsible for ensuring a private setting on their end for the therapy.

All information during the teletherapy session is confidential and protected. Similar to in-person therapy, however, there are limits to confidentiality. These limits include reporting child or vulnerable adult abuse, expressing imminent harm to oneself or others, or as required by a court of law.

I understand that despite using a privacy protected service, there are still breech of privacy risks such as: the transmission could be disrupted or distorted by technical failure, the transmission could be interrupted by unauthorized persons.

Teletherapy sessions will not be recorded or videotaped by the therapist or client. For privacy reasons, I agree not to record or videotape any therapy sessions.

I agree to let my therapist know the address I am located at in case of an emergency situation arising such as ill health, or mental health distress.

Billing and Cancellations

Teletherapy is billed as a regular appointment. It is billable to insurance or private pay rates apply. 24-hour cancellation notice is required. $100.00 no show, $85.00 late cancel (less than 24 hours) are assessed to client.

Discontinuation of Teletherapy Services

Teletherapy services may be discontinued by the therapist or client. The therapist may decide that the client would be better served by in-person sessions. The client may also discontinue services. Services may be discontinued if privacy or confidentiality are not established, or if technical issues interfere with communication.

I have the right to discuss any of this information with my therapist and to have any questions I may answered to my satisfaction.

I have read and understand the information provided above. My signature below indicates I have read this agreement and agree to its terms.

_____ _____

Client Signature **Date**

_____ _____

Therapist Signature **Date**

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes			❑ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes			❑ No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	❑ Yes			❑ No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	❑ Yes			❑ No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	❑ Yes			❑ No		
	25.	Have you EVER tried to kill yourself?	❑ Yes			❑ No		