Psychology Intake Form

What led you to seek psychological services for your child and/or family?

_____

_____

_____

Has your child ever been evaluated or treated by a psychologist or psychiatrist in the past? ☐ Yes ☐ No

If yes, when and for what reason(s)? _____

_____

Indicate which stressors your child is experiencing now (within last 6 months) or has in the past:

Now	Past		Now	Past		Now	Past	
☐	☐	Death of family member	☐	☐	Illness of family member	☐	☐	Illness of friend
☐	☐	Personal injury/illness	☐	☐	Parents separated	☐	☐	Parents divorced
☐	☐	Conflicts within family	☐	☐	Conflicts with friends	☐	☐	Conflicts at school
☐	☐	Academic difficulties	☐	☐	Change in residence	☐	☐	Legal problems
☐	☐	Sexual abuse	☐	☐	Physical abuse	☐	☐	Verbal/emotional abuse

Other Concerns: _____

Please check all that apply to your child:

- ☐ Suicidal thoughts
- ☐ Depression/sadness
- ☐ Anxiety/nervousness
- ☐ Recurrent/intrusive thoughts
- ☐ Nightmares
- ☐ Academic difficulties
- ☐ Loss of appetite or over-eating
- ☐ Weight loss or gain
- ☐ Recurrent/intrusive disturbing recollections or dreams
- ☐ Overwhelming need to perform certain behaviors/rituals
- ☐ Excessive fears or phobias
- ☐ Significant concerns with physical problems
- ☐ Difficulty sleeping
- ☐ Poor frustration tolerance
- ☐ Explosive anger
- ☐ Fatigue
- ☐ Rapid mood changes
- ☐ Loss of interest in almost all activities
- ☐ Feeling worthless
- ☐ Racing thoughts
- ☐ Feelings of hopelessness
- ☐ Decreased need for sleep
- ☐ Poor self esteem
- ☐ Aggressive
- ☐ Visual or auditory hallucinations
- ☐ Stomach aches
- ☐ Unmotivated
- ☐ Bizarre behavior
- ☐ Overly dependent
- ☐ Shy and withdrawn
- ☐ Quiet

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- ☐ Harms self on purpose
- ☐ Resists change
- ☐ Self-stimulates
- ☐ Wetting bed or clothes
- ☐ Exhibits sexually inappropriate behavior
- ☐ Picks at skin or pulls out hair
- ☐ Overly emotional
- ☐ Immature for age
- ☐ Is very fidgety
- ☐ Can't remain seated
- ☐ Can't wait his/her turn when playing with others
- ☐ Answers before s/he hears the whole question
- ☐ Rarely follows other's instructions
- ☐ Easily lies to others
- ☐ Steals things
- ☐ Destroys other people's property
- ☐ Irritable
- ☐ Is cruel to animals
- ☐ Starts fights with others
- ☐ Homicidal thoughts
- ☐ Other unusual behavior: _____

What are your goals for evaluation and/or therapy?

_____

_____

_____

What are 3 positive qualities about your child?

1. _____
2. _____
3. _____

Policies and Procedures:
Psychotherapy Consent for Treatment

Client Name: _____ Date Reviewed: _____

Purpose:
The purpose of this document is to inform clients of their rights and the clinician's expectations regarding the provision of psychological treatment.

Confidentiality:
In most cases, records of treatment will be kept fully confidential, and will not be released without the written consent of the client or the client's responsible party. Such records are also kept locked, and are only accessible by the clinician. Your rights to access your records are provided in a separate document called 'Notice of Privacy Practices' under HIPAA.
In the following situations, records may be released without the consent of the client, as it is required by law that mental health professionals report such issues:

- If threats to harm self or others are made
- Child, Care Dependent, or Elder Abuse
- When ordered via a Court Order
- If a malpractice or other complaint is filed with licensing entities
- Managed Health Care Inquiries
- In the above circumstances, only information required will be released, and the client will be informed of such releases.

Psychotherapy Expectations:

1. Psychotherapy is a joint effort between the child, family and the clinician. As such, it will be expected that you and the clinician exert similar levels of effort in the process. This will likely involve the completion of homework assignments between sessions as well as shared problem solving during treatment sessions.
2. When possible, the clinician will provide an estimated, expected length of treatment to the client. Any adjustments to the estimate will be shared with you as soon as such a change becomes evident.
3. You are expected to maintain all appointments scheduled with the clinician. Except in cases of emergency, 24 hour notice is expected to cancel an appointment.
4. Psychotherapy sessions typically will last for a period of 50 minutes. If a different length of time is felt necessary by the clinician, you will be informed in advance.
5. If it becomes evident that the therapeutic relationship is not successful, the clinician will assist you in obtaining treatment from another mental health professional.
6. As a component of your treatment a psychological intake will be completed during the first few sessions during which a history will be obtained as well as details regarding current difficulties.

Clients will also be asked to complete a questionnaire, which will need to be returned completed by the second session.

7. Treatment goals will be established by the third session and will be developed jointly between the clinician and you. These goals will guide the treatment process. Treatment goals will be updated every three months.

Treatment of Children and Adolescents:

1. For children and adolescents under the age of 14: All information regarding your treatment will be shared with your parent(s) or legal guardian as deemed necessary by the clinician for your treatment. Parent(s) or Guardian(s) will need to sign this consent for your treatment.
2. For adolescents age 14 and older: Legally, you have the right to full confidentiality regarding your treatment. However, the clinician will share information with your parent(s) or guardian(s) without your consent in situations where risk of harm is involved, such as suicidal behavior, self-harm behavior, homicidal behavior, or any other behavior deemed by the clinician to be a risk behavior. You must consent to these forms of communication in order to be considered for treatment at New Day Psychological Services.
3. You may sign consent for your own treatment; however, your parent(s) or guardian(s) will also be required to cosign for your treatment in order for treatment to be provided.
4. Except in cases where the child/adolescent's biological parents are married and living in the same household or where legal documentation regarding custody arrangements can be provided, the written consent of both parents will be required before any form of treatment will be provided.

General Considerations/Expectations:

1. Your treatment is being provided in order to assist you in addressing your current behavioral and emotional needs only. Unless specifically agreed to, your treatment record is not to be utilized for forensic purposes e.g. for issues that will be addressed in court, such as custody issues, legal issues etc. By signing this Informed Consent Document, you are agreeing not to attempt to have your records of treatment utilized for such purposes. In the event that you breech this agreement, court officials will be notified of this breech upon any requests made for records.
2. EBS Children's Institute is not a 24 hour service, however if you contact the office during non-office hours, you will be provided with appropriate contact information for your clinician. In the event of a crisis situation, you may either contact Crisis Intervention at 610-280-3270 (Child) & 610-280-3270 (Adult) or go to your local hospital's emergency room.
3. Generally, clients should only contact the office between sessions regarding issues with their appointments e.g. the need to cancel or reschedule. If you or your child experience an increase

in symptoms or difficulties and feel that you need an appointment sooner than your next scheduled visit, you may contact the office and every effort will be made to accommodate your need. Due to scheduling issues, however, this may not always be possible.

4. Clients may make contact with the office via phone as well as via e-mail. However, clients should keep in mind that e-mail is not secure and if they choose to utilize e-mail to communicate they assume all confidentiality risks in this regard.
5. The giving of gifts of any kind to the clinician is prohibited as per the Ethical Guidelines that mental health professionals are required to follow. As such, any gifts offered will not be accepted. If you have a desire to give a gift, as an alternate option, you may choose a charitable organization and provide your gift to that organization.

Additional Notes/Comments: _____

_____

Signatures:
My signature indicates that the content of this Informed Consent document has been reviewed with me, and I consent for my child to be provided treatment. I have been provided with the opportunity to ask any questions I have about the services to be provided as well as the other policies outlined in this document. I have also been provided with a copy of this document.

For individuals under the age of 18, the signature of at least one responsible person is required.

_____	_____	_____
Signature of Responsible Party	Relationship	Date

_____	_____	_____
Signature of Responsible Party	Relationship	Date

Policies and Procedures:
Psychotherapy Consent for Treatment

Child/Adolescent's Assent

My signature indicates that the content of this Informed Consent document has been reviewed with me and I understand this information. While I do not have the legal right to consent to treatment, I do agree to being provided with treatment and also agree to the policies outlined in this document that pertain to my treatment.

_____ _____

Child/Adolescent Signature Date