RSC Refined Strength Counseling
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Adolescent / Teenage Intake Form

This Packet Includes

Documents	Directions
Confidential Adolescent & Teenage Information	Complete & Return to Office
Policies & Procedures	Complete & Return to Office
Confidential Questions	Complete & Return to Office

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Confidential Adolescent /Teenage Information

Date _____

Parent / Guidance Information

Name:_____ Age_____ DOB _____ SS# _____

Address _____ City_____ State ____ Zip ____

Home Phone ( ) _____ Work ( ) _____ Cell ( ) _____

Where do you prefer to receive calls? ____ Home _____Work ____Cell

Can we leave a message at this number? ___Yes ___ No

Marital Status:

Single____ Married____ Separated___ Divorced____ Widowed____

Length of marriage: Current: ___years

Number & Length of other marriages: _____

Employer _____ Phone _____

Spouse: _____ Age____ DOB _____ SS# _____

Address _____ City_____ State ____ Zip ____

Home Phone ( ) _____ Work ( ) _____ Cell ( ) _____

Where do you prefer to receive calls? ____ Home _____Work ____Cell

Can we leave a message at this number? ___Yes ___ No

ETHNICITY:

__White _ Black or African American _ Asian _ Hispanic or Latino

_ American Indian or Alaska Native _Native Hawaiian or Other Pacific Islander _Other:

FAITH PREFERENCE:

_ Christian/Protestant _ Catholic _ Jewish _ Muslim _ Hindu _ Other:

Congregation Affiliation:

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ADOLESCENT / TEENAGE INFORMATION:

Name: _____ Sex __M __F DOB _____

Place of Birth _____ Age_____ SS# _____

Address _____

City _____ State _____ Zip _____

Education (grade) _____ Present School _____

Siblings (Name / Age) _____

PHYSHOSOCIAL HISTORY:

Current family Situation:

Mother – Relation to child ___Natural parent ___Relative ___Adoptive Parent

Occupation _____

Education _____

Father – Relation to child ___Natural parent ___Relative ___Adoptive Parent

Occupation _____

Education _____

Marital History of Parents:

Natural Parents:	_____ Married	When_____ Age _____
	_____Separated	When_____ Age _____
	_____Divorced	When_____Age _____
	_____Deceased	M or F_____ Age _____
Step Parents:	_____Married	When _____ Age _____

If child is adopted:

Adoption Source: _____

Reason and Circumstances: _____

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Age when child first in home: _____

Date of legal Adoption _____

What has the child been told? _____

CHIEF COMPLAINT:

Presenting problems (check all that apply)

_____ Very Unhappy	_____ Impulsive	_____ Fire Setting
_____ Stubborn	_____Stealing	_____ Temper Outburst
_____ Disobedient	_____Withdrawn	_____ Infantile
_____ Sexual trouble	_____ Lying	_____ Irritable
_____ Daydreaming	_____ Mean to others	_____School performance
_____ Fearful	_____Destructive	_____ Truancy
_____ Clumsy	_____ Trouble with the Law	_____ Bed wetting
_____ Overactive	_____ Running away	_____ Soiled pants
_____ Slow	_____ Self-mutilating	_____ Eating problems
_____ Short attention span	_____ Head banging	_____ Sleeping problems
_____ Distractible	_____ Rocking	_____ Sickly
_____ lacks initiatives	_____ Shy	_____ Drugs
_____Undependable	_____ Strange behavior	_____ Alcohol use
_____ Peer conflict	_____ Strange thoughts	_____ Suicide talk
_____ Phobic		

Explain: _____

Problems perceived to be: _____ Very serious; _____ Serious; _____ Not serious

How long have these problems occurred? _____weeks; _____ months; _____years

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What happened that makes you seek help at this time? _____

What are your expectations of your child? _____

What changes would you like to see in your child? _____

What changes would you like to see in yourself? _____

What changes would you like to see in your family? _____

CHILD HEALTH INFORMATION

Note: Includes all health problems the child has had or has now

	AGE		**AGE**
_____ High fevers	_____	_____ Dental problems	_____
_____ Pneumonia	_____	_____ Weight	_____
_____ Flu	_____	_____ Allergies	_____
_____ Encephalitis	_____	_____ Skin Problems	_____
_____ Meningitis	_____	_____Asthma	_____
_____ Convulsions	_____	_____ Headaches	_____
_____ Unconsciousness	_____	_____ Stomach Problems	_____
_____ Concussions	_____	_____ Accident	_____
_____ Head Injury	_____	_____ Anemia	_____
_____ Fainting	_____	_____ High/Low Blood Pres.	_____
_____ Dizziness	_____	_____ Sinus Problems	_____
_____ Tonsils Out	_____	_____ Heart Problems	_____
_____ Vision Problems	_____	_____ Hyperactivity	_____
_____ Hearing Problems	_____	_____ Other Illnesses	_____

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Has the child ever been hospitalized? _____ Yes _____ No

Age: _____ How Long: ____ Reason: _____

Has the child ever been seen by a medical specialist? _____ Yes _____ No

Age: _____ How Long: ____ Reason: _____

Has the child ever taken, or is presently on any prescribed medication? ___ Y ___ N

Age: _____ How Long: ____ Reason: _____

Name of Primary Care Physician: _____

EDUCATIONAL HISTORY:

PRESCHOOL:

Name of School _____

City _____ State _____ Zip _____

Dates Attended: From _____ to _____ Grades Completed _____

ELEMENTARY:

Name of School _____

City _____ State _____ Zip _____

Dates Attended: From _____ to _____ Grades Completed _____

JUNIOR HIGH

Name of School _____

City _____ State _____ Zip _____

Dates Attended: From _____ to _____ Grades Completed _____

HIGH SCHOOL

Name of School _____

City _____ State _____ Zip _____

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Dates Attended: From _____ to _____ Grades Completed _____

Types of Classes: _____ Regular _____ Learning Disability _____ Continuation

_____ Opportunity _____ Emotionally Handicapped _____ Other

Did child skip a grade? _____ Yes _____ No

Repeat a grade? _____ Yes _____ No

ACEDEMIC PERFORMANCE

Highest grade on last report card? _____ Lowest grade on last report card? _____

Favorite subject? _____ Least favorite subject? _____

Does child participate in extracurricular activities? Y N

List Activities: _____

In school, how many friends does child have? __ A lot __ A few __ None

What are the child's educational aspirations?

_____ Quit School _____ Graduate from High School _____ Go to College

Has child had special testing in school? (If yes, what were the results?)

Psychological _____ Yes _____ No

Vocational _____ Yes _____ No

List child's special interests, hobbies, skills: _____

_____

Has the child ever had difficulty with the police? _____ Yes _____ No

(If yes, explain) _____

Has the child ever appeared in juvenile court? _____ Yes _____ No

(If yes, explain) _____

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Has the child ever been on probation? _____ Yes _____ No

(If yes, explain) _____

From _____ to _____ Reason _____

Probation officer: _____

Has child ever been employed? _____ Yes _____ No

Employer _____

Job title _____

Start Date: _____, End Date: _____

ADDITIONAL COMMENTS: _____

_____

Counselor _____ **Date:** _____

COUNSELING SERVICES

After the initial evaluation, you and your counselor will decide if he/she is the best person to provide the services which you need in order to meet your treatment objectives. If you choose to continue, your counselor will work with you to determine your treatment plan. Counseling is a process in which the client and counselor work together to help solve problems, explore feelings and work towards goals. In order for this to be successful, you will need to work on goals or assignments between sessions.

Please note that it is impossible to guarantee any specific results regarding your counseling goals; however, together we will work to achieve the best possible results for you. Respect, cooperation, and professionalism will characterize this therapeutic relationship at all times. Some clients may need only a few sessions to achieve their goals; whereas, others may choose to come for an extended period of time.

As a client, you are in complete control and may end the counseling relationship at any point.

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CONFIDENTIALITY

In general, the confidentiality of all communications between a client and the counselor is protected by law, and information cannot be released without your written permission.

However there are some exceptions:

You sign a release directing disclosure of information to another professional or to someone else of your choosing.

If you choose to file insurance, your insurance company may have access to your records. Insurance companies usually require a specific clinical diagnosis, determined by the therapist, when claims are filed for mental health services. This diagnosis most likely will become a permanent part of your record. We cannot guarantee that our services will be covered by your policy or insurance company.

A court of law by a subpoena may under certain circumstances require the counselor to testify and/or release client files. It is our policy NOT to be involved in legal issues. If you have knowledge that your case is or may lead to a legal issue, we will make an appropriate professional referral. However, if a counselor receives a subpoena involving you, you will be responsible to pay $150.00 per hour for the time and expense spent in responding to the subpoena.

In accordance with the highest of ethical standards and with accordance to state and federal law, if a client intends to take harmful or dangerous action against another human being or against himself/herself, a counselor has a duty to warn:

1. Appropriate state or local agencies
2. The person who is likely to suffer the result of harmful behavior,
3. The family of the person who is likely to suffer the result of the harmful behavior,
4. The family of the client who intends to harm himself/herself,

In cases of **suspected or known** past or current abuse/neglect against a **minor child or elderly person,** the counselor has a responsibility to notify appropriate authorities (such as Child Protective Services).

Your counselor may consult with another professional on your case. Every attempt will be made to ensure that your identity will remain anonymous. The professional who is consulted is held to the same limits of confidentiality outlined here.

- **Please discuss with your counselor any questions or concerns you may have regarding the limits to confidentiality.**

FINANCIAL POLICY

- The fee for a 45-minute session is $110.00.
- FULL Payment is required at the time services are rendered and is the responsibility of the client or guarantor.
- Please discuss the possibility of alternative fee arrangements if the cost would prevent you from coming.
- **Refined Strength Counseling (RSC)** does not currently participate in managed care agreements with insurance companies. We will provide you with a **RSC** invoice **for you to submit to your provider** for reimbursement. The full payment is due at the time of service even if you are going to file with a third party.
- Please initial here _____ to state that you agree with the terms of our financial policies.

APPOINTMENTS

Counseling sessions are 45-50 minutes. For counseling to be effective several things are required among which are commitment to the process through faithfully attending appointments; completing "homework assignments" between sessions; establishing clearly defined goals (the counselor will help do this in the first session);

- Please be on time for your appointment and have all necessary paperwork completed
-

- All cancellations must be made at least 24 hours prior to your scheduled appointment time.
- Cancellations with less than 24 hours' notice will be charged one half of your counselor's normal fee.

PERMISSION FOR PROFESSIONAL SERVICES FOR A MINOR

Children over the age of 16 are considered legal adults when involved in mental health services. Confidentiality in these situations is restricted by the same above laws that apply to adults. Before the age of 16, communication of confidential information between counselor, client and parents or legal guardians is at the discretion of the counselor.

Parents of children 15 years and younger should remain in the building and in close proximity to the counseling office during the counseling session. Please notify us if you must leave the building for any reason and leave a cell number to contact you. All parents/legal guardians of children

17 years and younger please read and sign.

I have the legal authority to seek and grant permission for professional services for my minor child _____, birth date __/__/___, there being no legal decree disallowing my authority to assume such responsibility,

_____.

(Parent/legal guardian signature)

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CONSENT FOR COUNSELING

I have read and understand the policies and procedures of Refined Strength Counseling regarding the Counseling Services, Financial Policy, Appointments, Confidentiality and Permission for Professional Services for a Minor. All adult members of your family who are involved in this counseling need to sign below, indicating understanding of these policies and procedures.

Client Signatures: _____ Date: _____

Client Signatures: _____ Date: _____

Client Signatures: _____ Date: _____

Counselor's Signature: _____ Date: _____