



Counseling is a cooperative venture with responsibility resting on both the counselor and the client. Please read the information below carefully. If you have any questions I will be happy to discuss them with you. Counseling is provided from a Christian perspective for individuals, couples, families, and groups. Services are available to residents of the community regardless of religious affiliation.

**Confidentiality:**

The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law”, HIPPA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage access to health care records. HIPPA applies to all health care providers, including mental health care. An explanation of those rights is attached to this document for your keeping. Communications between client and counselor are confidential and will not be revealed ***unless required by law*** such as in situations of child abuse or threats of physical harm to self or others. Your counselor will discuss confidentiality and its exceptions with you. =

**Counseling Fees:**

The fee for a regular 50-minute session is \$120. We ask that your account be kept current and that you pay following each session. Payments can be made in advance on my website or by check, cash or credit card at the scheduled appointment time. Should the fee not be paid for two sessions, no further sessions will be scheduled until the balance is paid. Please make checks payable to: **Flourish Counseling**

**Insurance:**

Billing insurance companies for service is not provided, though occasionally clients may be reimbursed for services directly. However, ultimate responsibility for payment is yours. We ask that you pay for services and we will provide paperwork for your insurance company to reimburse you.

**Cancellation of Appointments:**

If you must cancel your appointment, please notify me at least 24 hours in advance of your scheduled appointment. You may email [contact@joannahsadler.com](mailto:contact@joannahsadler.com) and leave a message at 770-847-0160. A charge of ½ the regular fee will be made for the time reserved when cancellations are received less than 24 hours in advance, except in the case of illness or other emergency. Your cooperation in this regard will be greatly appreciated.

I have read the above information and agree with these terms and conditions. I voluntarily request counseling services at Flourish Counseling, LLC.\*

Signature \_\_\_\_\_ Date \_\_\_\_\_

*\*The signature of the custodial parent or guardian is required for clients under the age of 18.*

Flourish Counseling, LLC

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**CHILD & ADOLESCENT INTAKE QUESTIONNAIRE** The following questionnaire is to be completed by the parent or guardian. This form has been designed to provide necessary information to our staff before our initial conference in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information which you think may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request. Please use the backs of the pages for additional details.

## CHILD AND ADOLESCENT INTAKE FORM

### BACKGROUND INFORMATION

Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Child lives with (✓ one):    both biological parents \_\_\_\_\_ mother \_\_\_\_\_ father \_\_\_\_\_  
   mother & stepfather \_\_\_\_\_ father & stepmother \_\_\_\_\_ other \_\_\_\_\_

If parents are divorced, describe custody arrangements: \_\_\_\_\_

Child's Address/City/St/Zip \_\_\_\_\_

Child's Home Phone \_\_\_\_\_

Parent/Guardian Phone Number: \_\_\_\_\_

Emergency Contact Person (other than parent) \_\_\_\_\_ Phone Number \_\_\_\_\_

### INFORMATION ABOUT CHILD'S MOTHER

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Hrs/wk \_\_\_\_\_

Employer's Address \_\_\_\_\_

Can you be contacted at work by phone?    Yes    No    Work phone \_\_\_\_\_ ext \_\_\_\_\_

Denomination \_\_\_\_\_ Church \_\_\_\_\_ Active?    Yes    No

Describe any physical problems you have that require medication or physical care? \_\_\_\_\_

Are you currently receiving medical treatment?    Yes    No    Physician \_\_\_\_\_

Medication(s) currently using \_\_\_\_\_

Previous Counseling / Therapy?    Yes    No    If yes, when? \_\_\_\_\_

With whom and for how long? \_\_\_\_\_

**INFORMATION ABOUT CHILD'S FATHER**

Father's Name \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Hrs/wk \_\_\_\_\_

Employer's Address \_\_\_\_\_

Can you be contacted at work by phone?    Yes    No    Work phone \_\_\_\_\_ ext \_\_\_\_\_

Denomination \_\_\_\_\_ Church \_\_\_\_\_ Active?    Yes    No

Describe any physical problems you have that require medication or physical care? \_\_\_\_\_

Are you currently receiving medical treatment?    Yes    No    Physician \_\_\_\_\_

Medication(s) currently using \_\_\_\_\_

Previous Counseling / Therapy?    Yes    No    If yes, when? \_\_\_\_\_

With whom and for how long? \_\_\_\_\_

**FAMILY MEMBERS**

List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime:

Name	Relationship to Child	Age	Highest School Grade Completed	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**DESCRIBE THE PROBLEM** If possible, list questions for which answers are sought: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Problem Areas:** In the following list, place a check mark (✓) next to each item which identifies an area of concern to you. Place 2 check marks (✓✓) by those items which are most important. (You may add written comments after areas checked.)

_____	Anger / Temper	_____	Sexual Concerns
_____	Depression	_____	Thoughts of Suicide
_____	Education	_____	Trouble making decisions
_____	Family Problems	_____	Unhappy most of the time
_____	Fearfulness	_____	Use of Alcohol
_____	Marital Problems	_____	Use of Drugs
_____	Physical Problems	_____	Work
_____	Problems with Social Relationships	_____	Worry
_____	Problems with Children	_____	Other (specify) _____
_____	Religious / Spiritual Concerns	_____	_____

**MEDICAL HISTORY**

List child's sickness, operations, and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:

\_\_\_\_\_  
\_\_\_\_\_

Have there been any previous psychological, psychiatric, neurological, or EEG evaluations?    Yes    No

If so, please list names, addresses, and dates of contact: \_\_\_\_\_

Indicate any continuing medication treatment: \_\_\_\_\_

How is child's vision? \_\_\_\_\_

How is the child's hearing? \_\_\_\_\_

Describe previous speech or hearing therapy, if any: \_\_\_\_\_

When did your child last have a physical examination? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Would like Child to do More Often

Would like Child to do Less Often

- |          |       |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |

Describe your child's strengths, positive qualities, and any special abilities or skills:

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**FAMILY STRESS LEVEL**

Please rate the overall level of FAMILY stress:

\_\_\_\_\_ Very Low \_\_\_\_\_ Low \_\_\_\_\_ Average \_\_\_\_\_ High \_\_\_\_\_ Very High

What is the greatest source of stress for the family at this time?

Please rate the overall level of stress in the mother's life:

\_\_\_\_\_ Very Low \_\_\_\_\_ Low \_\_\_\_\_ Average \_\_\_\_\_ High \_\_\_\_\_ Very High

What are the greatest sources of stress in the mother's life?

Please rate the overall level of stress in the father's life:

\_\_\_\_\_ Very Low \_\_\_\_\_ Low \_\_\_\_\_ Average \_\_\_\_\_ High \_\_\_\_\_ Very High

What are the greatest sources of stress in the father's life?

How would you rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY)

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

**ACADEMIC / SCHOOL INFORMATION**

School Name \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

List previous schools attended with dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has child ever repeated a grade? Yes No If so, when? \_\_\_\_\_

How does your child get along at school? \_\_\_\_\_

\_\_\_\_\_

Describe difficulties in learning at school: \_\_\_\_\_

\_\_\_\_\_

Have other family members had learning difficulties? \_\_\_\_\_

\_\_\_\_\_

Describe what your child likes to do for fun, special interests, hobbies, etc. \_\_\_\_\_

\_\_\_\_\_

Describe your child's religious background (religious denomination, is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I learned about Flourish Counseling from: Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

May we send a thank you note to this person? Yes No

Signature \_\_\_\_\_

Date \_\_\_\_\_