
***Kate Casey, LPC, JD***
270 Miron Drive, Suite 112
Southlake, Texas 79092

## CHILD & ADOLESCENT INTAKE ASSESSMENT

**Client's Name: _____Date of Birth: _____ Age: _____**
(mm / dd / yyyy)

**Gender:** M____ F____ **Ethnicity: _____ Referred by: _____**

**Child's Address_____**

**Current School _____ Current Grade Level: _____**

**Parent Contact Information:**

Name: _____ Relationship to child: _____

Place of Employment: _____

**I consent to being contacted at the following address:**

Street/Apt: _____

City/State: _____ Zip: _____

**I consent to being contacted at the following phone numbers, including texting/leaving voicemails:**

Home Phone: _(_____)_____ Cell Phone: _(_____)_____

Work Phone: _(_____)_____ Ext _____

**I consent to being contacted at the following email address** (optional)**: _____**

Note that cell phones and email cannot be guaranteed to be a confidential form of communication.

Parent's Marital Status: Married _____ Single (never married) _____ Divorced _____Separated

**Who is custodial parent or legal guardian? (check all that apply)**

____ Mother ____ Father ____ Legal Guardian: _____

**If the child is not living with both natural parents, both adoptive parents, or only living parent, Kate Casey, LPC, JD requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page. These pages must be provided before counseling can begin.**

**Emergency Contact Information:**

In the event of an emergency (e.g. a case where the therapist determines the client may be a danger to self or someone else), I give you permission to contact the following in addition to emergency services:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

**Approximate combined annual household income (check one):**

up to $40,000_____ $40,001-$60,000_____ $60,001-$80,000_____ $80,001-$100,000_____ above $100,000_____

**PRESENTING CONCERN:**

What are the problems that cause you to seek help here for your child? _____

_____

_____

How long has your child had these problems?

_____

How have you attempted before now to cope and/or deal with this issue(s)?

_____

**YOUR CHILD'S SYMPTOMS**

Please mark all characteristics or areas of concern that apply to your child. This is to help understand the symptoms you are seeing, not to label your child.

| | | |
|---|---|---|
| □ Aggressive | □ Angry | □ Argues |
| □ Assaults others | □ Bossy to others | □ Breaks the law |
| □ Bullied by others | □ Bullies others | □ Cheats |
| □ Complains of feeling sick | □ Conflicts at school | □ Conflicts at home |
| □ Conflicts with friends | □ Cries easily | □ Cruel to animals |
| □ Defiant | □ Dependent | □ Destructive |
| □ Developmental delays | □ Difficulties with parent(s) | □ Disobedient |
| □ Disrupts family activities | □ Distractible | □ Dropping out of school |
| □ Drug or alcohol use | □ Eating Issues | □ Failure in school |
| □ Fantasy life | □ Fearful | □ Feelings are easily hurt |
| □ Fidgety | □ Fire setting | □ Hair chewing |
| □ Hostile | □ Hyperactive | □ Imaginary playmates |
| □ Immature | □ Inattentive | □ Independent |
| □ Inflicts pain on others | □ Insults others | □ Intimidated by others |
| □ Intimidates others | □ Intolerant | □ Irritable |
| □ Isolates | □ Lacks respect for authority | □ Learning disability |
| □ Lethargic | □ Likes to be alone | □ Loss of friends |
| □ Low frustration tolerance | □ Lying | □ Manipulates |
| □ Moody | □ Mute, refuses to speak | □ Nail biting |
| □ Name calling | □ Negative attitude | □ Nervous |
| □ New school | □ Nightmares | □ Oppositional |
| □ Outgoing | □ Overactive | □ Pouts |
| □ Provokes others | □ Rages | □ Relationships with siblings |
| □ Relationships with teachers | □ Runs away | □ Sad |
| □ Self-harming behaviors (explain: _____) | | □ Sexual behavior |

| | | |
|---|---|---|
| □ Sexually active | □ Shy | □ Slow-responding |
| □ Smoking | □ Social | □ Speech difficulties |
| □ Stealing | □ Stubborn | □ Suicide talk or attempt |
| □ Swearing | □ Talks back | □ Teased |
| □ Teases others | □ Temper tantrums | □ Tics-movements or noises |
| □ Truancy | □ Uncooperative | □ Under-active |
| □ Unhappy | □ Violent | □ Wets/soils bed/clothes |

□ Other _____

**MEDICAL AND DEVELOPMENTAL HISTORY**

This is a very important section of our study of your child. The information you furnish is held in confidence. Please answer in the blanks provided.

Current Medical Problems? _____

_____

_____

_____

Present Medications (Names and Dosage): _____

_____

_____

**DISCIPLINE**

Child is most often disciplined by: _____

Discipline <u>most</u> effective with the child: _____

Discipline <u>least</u> effective with the child: _____

Explain briefly the child's most common reactions to discipline: _____

_____

**SOCIAL DEVELOPMENT**

Does the child have problems relating with:

Other Children?____ Teachers?_____ Brothers/Sisters?_____ Parents?_____ Other Adults?_____

Does the child have problems separating from… Mother? **Yes____ No____** Father? **Yes____ No____**

Does the child like to play with children: ____Own Age ____Younger ____Older

Does the child have: ____Many friends ____Few Friends ____No Friends

Is the child a: ____Leader ____Follower ____Loner

Hobbies or activities:_____

**EDUCATIONAL HISTORY**

Has the child ever participated in Special Education? **Yes____ No____**

If yes, what grades did the child participate in Special Education? _____

Has the child ever repeated a grade? **Yes___ No___** How many schools your child has attended? _____

Is your child currently experiencing difficulty in school? **Yes____ No____** If yes, describe

_____

Behavioral problems in school? **Yes___ No___** If yes, describe _____

Barriers to learning? **Yes___ No___** If yes, describe _____

School suspensions or expulsions? **Yes___ No___** If yes, describe _____

**JUVENILE HISTORY**

Has the child ever had problems involving the police or juvenile authorities? **Yes____ No____**

If yes, when and why?_____

_____

Is the child on probation? **Yes____ No____**

If yes, Where? _____ Child's Probation officer? ___ _____

**FAMILY COMPOSITION**

Please list family and/or significant others to the child and indicate if they live in the child's home.

| **Member** | **Relationship** | **Age** | **Occupation & Education** | **In Home?** |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | Y N |
| _____ | _____ | _____ | _____ | Y N |
| _____ | _____ | _____ | _____ | Y N |
| _____ | _____ | _____ | _____ | Y N |
| _____ | _____ | _____ | _____ | Y N |
| _____ | _____ | _____ | _____ | Y N |
| _____ | _____ | _____ | _____ | Y N |
| _____ | _____ | _____ | _____ | Y N |
| _____ | _____ | _____ | _____ | Y N |

**FAMILY HISTORY**

Has the child or child's parents experienced any of the following in their life?

| | | | |
|---|---|---|---|
| Deaths | **Yes____ No____** | Medical Problems | **Yes____ No____** |
| Violence in Family | **Yes____ No____** | Legal Problems | **Yes____ No____** |
| Moves | **Yes____ No____** | Financial Stressors | **Yes____ No____** |
| Physical or Sexual abuse | **Yes____ No____** | Addiction in Family | **Yes____ No____** |
| Suicide | **Yes____ No____** | | |

Explain any items marked Yes above: _____

_____

Significant family circumstances/stressors (current): _____

_____

Please list any significant family members who have died:

| Name | Role (i.e., parent, brother, grandmother) | Date of Death/Age of Client |
|---|---|---|
| | | |
| | | |
| | | |

**RELIGIOUS/SPIRITUAL HISTORY**

Your child's religion or spiritual practice: _____

How important is religion to your child? _____

How important is religion to your family?_____

**PREVIOUS TESTING OR THERAPY**

Has your child ever seen a mental health professional before (counselor, psychologist, psychiatrist, social worker)? **Yes____ No____** If yes, where and by whom?_____

_____

Approximately when and for how long did he/she attend therapy? _____

Previous Diagnosis? **Yes____ No____** If yes, list diagnosis: _____

Any delusions or hallucinations, past or present? **Yes____ No____** If yes, describe: _____

Any substance abuse issues, past or present? **Yes____ No____** If yes, describe: _____

Did treatment include medication? **Yes____ No____** If yes, what medications did he/she take and for how long? _____

Has your child ever been in residential treatment, inpatient psychiatric care, or hospitalized for reasons relating to suicidal ideation/attempts or mental health concerns? **Yes____ No____** If yes, please list the name of the facility, when/how long, and reason for admission: _____

_____

Effectiveness of therapy treatment: Positive _____ Negative _____ No Change _____

Reason(s) therapy was discontinued_____

_____

_____

_____

_____

Cash, checks, MasterCard, and Visa are accepted. Any unpaid balance may be turned over to a collection agency if you refuse to remain responsible for your account. You will be expected to pay for late, cancelled, or forgotten appointments at the full rate unless you have contacted Kate Casey, by phone, voicemail, or email to cancel 24 hours before your scheduled appointment.

I agree to the above statements. I consent to be contacted at any of the addresses, phone numbers, and emails provided above (5 pages) through mail, email, calling, texting, or voicemails. I will immediately notify the therapist of any change. I understand that cell phones and email cannot be considered to be secure and confidential forms of communication. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Relationship to Child | Date |

# Credit Card on File Authorization (required)

**Payment is due at time of service. Our office requires that a credit card be kept on file in the event of any unpaid balances, late cancellations, or missed appointments. Cash, checks, and other credit cards may still be utilized at time services are rendered for payment.**

Information to be completed by the card holder:

Cardholder Name: _____

Billing Address (required): _____

Email (optional, where statements may be sent): _____

I consent to the use of my credit card for appointments broken without 24-hour notice and for any unpaid fees or services: I understand that my card will be immediately charged the full fee for appointments cancelled or missed without 24-hours notice given. I agree to receive billing statements at the email address above that include dates and types of service. I understand that email cannot be guaranteed to be a confidential form of communication. I understand that I may choose not to provide an email address for billing, and any billing statements will instead be sent to the mailing address I have provided above. I attest that I agree to this document, and all the information provided is accurate to the best of my knowledge. I further attest that I am allowed to all the rights and privileges that are associated with this card.

_____ _____
Cardholder Signature Date

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Card Number: _____

Card Type: Visa MasterCard

Expiration Date: _____
CV Code:_____

***MC Visa and Discover are accepted.***

***Print your name:*** _____

**Kate Casey, LPC JD**
**270 Miron Drive, Suite 112**
**Southlake, Texas 76092**

## Limits of Confidentiality

Your disclosures here will remain confidential. My utmost concern is to guard your privacy. Nothing discussed here will be disclosed outside the therapy room, except in rare cases as required by law.

By law, it is necessary for me to report any information I have regarding the following*:*

**If you are planning to take your own life*
*******If I determine that you are a danger to someone else*
** You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person*
**If you have knowledge of abuse or neglect taking place in a mental health or Rehabilitative facility*
**If you are a minor---your parents have the right to know about your progress*
**If your records are subpoenaed in connection with a legal proceeding*
**If a professional offering mental health services is being sexual with you*
**If you are in therapy along with someone else (i.e., couples or family therapy), these notes are the property of both parties, and can be obtained by any of the parties involved.*
**If required by the Secretary of the Department of Health for investigating compliance with the Privacy Rule.*

If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

I consult regularly with other professionals regarding my clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

## Finances

**Therapy costs are as follows:**

| | |
|---|---|
| *50 minute individual session | $125.00 |
| *75 minute individual session | $185.00 |
| *50 minute couple/family session | $150.00 |
| *Premarital Counseling Package (to include Assessment and 6 sessions) | $900.00 |

Other services such as court appearances, travel time, writing reports or summaries, will be billed at the same rate of $125.00 per hour. I do not provide counseling services via email or text messaging. Should you need immediate mental health attention, you should call 911 or go to your nearest emergency room.

***Cancellations:*** **If you must cancel an appointment *for any reason*, please give at least 24-hour notice. Otherwise, you will be billed the regular session fee per the amount of time you scheduled.** Cancellations may be left on voicemail or email (817-881-1914 or Kate@AutumnRidgeLPC.com).

**If you are late to a session, I will wait 10 minutes, unless you call** (817-881-1914) to say you're on your way. Clients arriving late for a session will receive the remainder of the scheduled appointment slot (e.g. 2:00pm-2:50pm) and will be responsible for the full fee.

**Forms of Payment:** Cash, check, Visa and MasterCard are accepted as payment. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments. If your account is overdue (unpaid) and there is no written agreement on a payment plan, I can use legal or other means (courts, collection agencies, etc.) to obtain payment.

**Insurance Reimbursements*:*** Please note that this office does not accept insurance, but upon request, I can provide documentation of out-of-network services for you to submit to your insurance company, if you choose to do so. Cancellation fees are not likely to be covered. It is your responsibility to verify the specifics of your coverage. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk regarding confidentiality of computerized records.

## *My Contact Information*

Email: Kate@AutumnRidgeLPC.com / Phone/Voicemail/: 817-881-1914

If you need to contact me between sessions, please leave a voicemail on the phone number above and your call will be returned as soon as possible. I check my voice messages a few times during the daytime only, unless I am out of town. If an emergency situation arises, you can call 911, the Suicide Crisis Hotline 214-828-100 or 1-800-273-TALK, or the MHMR Crisis line at 817-335-3022 or 1-800-866-2465 or the Police. Please do not use the phone or email for emergencies as I cannot assure I will get your call/email in a timely manner.

The phone number listed is a cell phone number. Email and cell phones cannot be guaranteed to be a secure and confidential form of communication. It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. Please notify me if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, or phone messages. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters. Please do not use texts, e-mail, or voice mail for emergencies.

## *Emergencies*

I **do not** provide 24 hour crisis counseling. Should you need immediate mental health attention, you should call 911 or go to your nearest emergency room. If there is an emergency where I become concerned about your personal safety or the possibility of you injuring someone else, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may contact the police, suicide assessment services, or other emergency personnel and/or the person whose name you have provided on the biographical sheet as the emergency contact. You may request at any time to update your emergency contact person.

## Records

Unless otherwise agreed to be necessary, I retain clinical records only as long as is mandated by state law, five years from the last date of contact. If you have concerns regarding the treatment records, please discuss them with me. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. Considering all of the above exclusions, if it is still appropriate, and upon your request, I will release information to any agency/person you specify in writing. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

## Agreements

**Mediation:** I agree that I will seek mediation in the event of any dispute with the therapist regarding the therapist-client relationship. All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator chosen will be one to which both parties can agree. The costs of mediation shall be equally shared. Judgment upon the award entered by the mediator shall be binding upon the parties and may be entered by either party in a court of competent jurisdiction.

**Court Involvement:** I agree that I am seeking treatment for the purpose of therapy only and not for legal purposes. I waive the right to subpoena the treating therapist. If the therapist is subpoenaed by any party, I agree to compensate the therapist for time spent producing records and being present in court at the full rate of $85 per hour with a minimum of two hours per court date.

**Therapist's Incapacity or Death:** I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request, or deliver them to a therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

**Contact:** I consent to the telephoning of my home, business, or cell phone numbers I have provided on the intake assessment form, including texting or having messages left on voicemail. I consent to communication by email for any email address I have provided. I understand that communication via email or on a cell phone is not considered secure and confidential.

**Emergency Contacts:** In the event that Kate Casey, LPC, JD reasonably believes that I am a danger to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact any person in a position to prevent harm to myself or another person, in addition to suicide assessment services, medical and law enforcement personnel, and the following persons:

| Name | Relationship | Phone |
|---|---|---|
| | | |
| | | |
| | | |

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that I have received and reviewed. I acknowledge the potential of the redisclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule.

A photocopy or fax of this consent is as valid as the original.

I have read and understand the above information and agree to the limitations and restrictions set forth herein. I have received a copy of this document and any questions have been answered to my satisfaction. **I voluntarily agree to receive mental health care, assessment, treatment, or services and understand I can terminate such services at any time**.

_____ _____

Client Signature Date

_____ _____

Kate Casey, LPC, JD Date


**Kate Casey, LPC, JD**
**270 Miron Drive, Suite 112**
**Southlake, Texas 76092**

## Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have read and understand this office's Notice of Privacy Practices, available in paper format in the office and online at www.AutumnRidgeLPC.com. Any questions I had have been answered to my satisfaction. I understand that I may request a paper copy to take with me at any time and one will be provided to me.

Patient name: _____

Signature: _____ Date: _____

It is your right to refuse to sign this document

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**For Office Use Only:**

**The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:**

**_____ Patient refused to sign.**

**_____ Communication barriers prohibited obtaining the acknowledgement.**

**_____ An emergency situation prevented this office from obtaining it.**

**_____ Others: _____**