JAKE LEHRER, M.A., LMFT

II *6607 18th Avenue South, Suite #101 Richfield, MN 55423* II *lakewoodcounseling.com* II *(P) 612-798-7373 (F) 612-243-3615* II

Adolescent Intake Form

Name:_____ Age:_____ Cell # :_____

Please answer these questions as completely as possible. You can discuss any topic more fully when you meet your therapist. It is your choice whether or not you answer any specific question(s). The purpose of this form is to help your therapist understand you, your background, and your concerns. This will not be shared with anyone else parents. THIS IS FOR YOUR THERAPIST ONLY.

Please describe the issue or concern that brings you to therapy, including specific symptoms or problems you MOST want to address:

Check any of the following statements that are true for you. *USE SPACE NEXT TO STATEMENT TO PROVIDE MORE INFORMATION, IF YOU WISH.*

___ I've been told or think I have ADD/ADHD

___ Others have expressed worry about my eating habits

___ I get angry a lot

___ I worry often

___ I think about hurting or killing myself

___ At times, my life or future seems hopeless

___ I'm comfortable with my eating habits

___ My parents think I sleep too much

___ Thoughts seem to race in my head a lot

___ I have a hard time concentrating when I need to

___My energy levels are lower than I'd like

___ I get frustrated easily

___ My mood seems to go up and down quickly and/or severely

___ I avoid conflict

___ I feel stressed a lot

___ I feel successful about school

___ I cry quite a lot

___ I get angry and I don't know why

___ I feel guilty about things often

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Check any of the following statements that are true for you. ***USE SPACE NEXT TO STATEMENT TO PROVIDE MORE INFORMATION, IF YOU WISH.***

___ I get sad for no reason

___ I'm scared at home and/or school

___ I get all of my homework done on time

___ I'm bored with school

___ I have trouble falling and/or staying asleep

___ Myself or others have said they think I sleep too much

___ I have good friends

___ I feel supported by my family

___ My parents do not like my friends

___ I'm happy with my success in school

___ I feel people in my family do not care about me

___ My parents and I get along pretty well

___ My siblings and I get along fine

___ My friends have said that they worry about me

___ My parents put too much pressure on me

___ I worry about someone in my family

___ There is a lot of conflict in my house

___ My parents are too controlling

___ I have trouble making or keeping friends

___ I like myself

___ I know what I am good at

___ I feel my strengths outweigh my weaknesses

___ I feel comfortable at my school

___ I am comfortable with my looks

___ My weight is an issue for me

___ I wish I could change certain things about me or my life or family

___ I am sexually active

___ I have concerns about certain sexual things

___ My parents and/or friends express worry about my sexual activity

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Check any of the following statements that are true for you. ***USE SPACE NEXT TO STATEMENT TO PROVIDE MORE INFORMATION, IF YOU WISH.***

___ I am often very jealous of certain people and it bothers me / others

___ I am NOT clear about my sexual orientation and/or gender (gay, straight, bisexual, transgender)

___ I like being in committed relationships

___ My culture, religion, and/or ethnicity is an issue for me

___ I have experience with drugs and alcohol

___ I currently use drugs and/or alcohol

___ Others have expressed worry or concern about my use of drugs and/or alcohol

___ I have been in trouble with the legal system before

___ I am concerned about someone else's use of drugs and/or alcohol

___ Sometimes I think I overuse the internet, videogames, etc.

___ Sometimes I think I overuse pornography or I may have a pornography addiction

___ My parents think I am addicted to screens/electronics

Are you currently having any other *specific* problems at work, school, home? Please describe:

Chemical Health History (Alcohol, Illegal Substances, Non-Prescribed Substances, Tobacco, other)

Substance	Age When 1st Tried	Date of most recent Use	Frequency of Use in Last Six Months (how often)	Amount Used Typically

Have there been any negative consequences as a result of your chemical use? i.e., DUI's, arrests, charges, relationship difficulties, etc. If yes, please describe.

Previous chemical abuse treatments? Describe (where, when, comments):

OVER →

My personal strengths:

My personal challenges/weaknesses:

Losses I have experienced (Who/What?... ..When?..... How/Why?.)

Something that I would change about my family:

What do you want to get out of therapy?

Would doing family therapy be helpful in addition to your individual therapy? How? What issues would YOU address in family therapy?

Is there anything else you want to share?:

THANK YOU

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ADULT INTAKE FORM

Name: _____ Age:_____ Date: _____

Best phone # to contact you at: _____

Please answer these questions as completely as possible. You can discuss any topic more fully when you meet your therapist. It is your choice whether or not you answer any specific question(s). The purpose of this form is to help your therapist understand you, your background, and your concerns. THIS IS FOR YOUR THERAPIST ONLY.

Please describe the issue or concern that brings you to therapy, including specific symptoms or problems you MOST want to address:

Describe what you have already done to try and deal with your concerns.

Please complete by assigning a number to each problem listed, using the key below. Leave blank if you've never had the symptom. ***Use space next to an issue to provide more information, if you wish.***

Do you have any of the following symptoms regularly or severely enough to cause you concern?

1 - In the *past*, but not now
2 - *Some* of the time (current)
3 - *Most* of the time (current)
4 - *All* of the time

____ ADD or ADHD concerns (even if undiagnosed)

____ Adoption issues

____ Alcohol or chemical abuse/dependency

____ Anger issues

____ Anorexia/bulimia/eating issues (binging, under/over-eating)

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1 - In the *past*, but not now
2 - *Some* of the time (current)
3 - *Most* of the time (current)
4 - *All* of the time

____ Attempting suicide

____ Avoidance of conflict

____ Bi-polar concerns

____ Body issues

____ Childcare/parenting

____ Child development/behavior problems

____ Cigarette addiction

____ Codependency

____ Communication problems

____ Compulsive/addictive behavior

____ Concern about another's alcohol or chemical use

____ Cyber/internet sex/pornography, computer gaming or online issues (i.e. over-use, compulsivity)

____ Depression

____ Dissociation

____ Divorce/separation

____ Elder parent issues

____ Fear/sense of not being safe

____ Feeling ashamed

____ Feeling guilty

____ Feeling sad

____ Feeling suicidal

____ Financial problems/concerns

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1 - In the *past,* but not now
2 - *Some* of the time (current)
3 - *Most* of the time (current)
4 - *All* of the time

____ Gender identity concerns

____ Isolation

____ Jealousy

____ Legal problems

____ Loneliness

____ Loss of concentration

____ Loss of energy

____ Loss/grief issues

____ Low self-esteem

____ Marital/couple conflict

____ Mood swings

____ Neglect

____ Occupational/job problems

____ Parent/child issues

____ Physical health issues

____ Physically/sexually abused as an adult

____ Physically/sexually abused as a child

____ School-related problems

____ Self-hate/self-loathing

____ Self-injury

____ Sexual identity/orientation

____ Sexual relationship issues

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1 - In the *past*, but not now
2 - *Some* of the time (current)
3 - *Most* of the time (current)
4 - *All* of the time

____ Sexuality concerns

____ Single parenting issues

____ Step-family issues

____ Verbal/emotional abuse

____ Other – *please elaborate*:

Have your symptoms impacted your daily functioning or caused you any problems at school, work or home? Please describe:

How would you describe your psychological/emotional health at the present time?

____ Poor ____ Fair ____ Average ____ Good ____ Excellent

Comments:

Please describe any current or past significant stressors in your life (school, work, relationships, financial,

etc.)

Are you aware of any family history of alcoholism, addiction, depression, anxiety, bi-polar, schizophrenia, or other mental illness? ____ Yes ____ No If yes, please describe:

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Chemical Health History (Alcohol, Illegal Substances, Non-Prescribed Substances, Tobacco, other)

Substance	Age When 1st Tried	Date of most recent Use	Frequency of Use in Last Six Months (how often)	Amount Used Typically

Have there been any negative consequences as a result of your chemical use? i.e., DUI's, arrests, charges, relationship difficulties, etc. If yes, please describe.

Have others expressed concern about your alcohol or drug use? ____ Yes ____ No If yes, please describe:

Are you worried about the drug or alcohol use of a significant person in your life - i.e. spouse, parent, child, sibling? ____ Yes ____ No If yes, please describe your concern:

How do you identify your sexual orientation? _____

Are you: ____ Single ____ Married ____Divorced ____ Widowed ____ In a significant relationship

Comments:

Describe any comments or concerns regarding your living situation:

Legal History:
Have you had any current or past problems with the legal system? Please describe:

Are you currently involved in any legal action/litigation? Please describe:

Do the reasons you are seeking services at Lakewood have to do with legal issues? Please describe:

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Work/Education:

Occupation/Title: _____ Employer:_____
Comments:

How satisfied are you with your occupation and why?: _____
_____
_____

High School Attended: _____ Year of Graduation: _____

College/University: _____ Year of Graduation: _____

College/University: _____ Year of Graduation: _____

Degree(s) Earned and Major(s): _____
Interests/activities: Please describe interests or hobbies and how you spend time during a typical day.

Described your attributes that you consider to be strengths:

Described your attributes that you consider to be a source of weakness, frustration or concern (for you or others):

How would you describe your ***physical*** health at the present time?

____ Poor ____ Fair ____ Average ____ Good ____ Excellent ____ Not sure

Medical Information:

Name of Primary Physician: _____ Phone:# _____

Name of Clinic: _____

Date and Reason of Last Physical Exam _____

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Current Medication(s)

Name	Dosage	Prescriber/Clinic	Date(s)

Do you take your medications regularly? If not, please explain, e.g., how often you miss doses:

Previous Medication(s)

Name	Dosage	Prescriber/Clinic	Date(s)

Previous Therapist(s)

Name/Clinic	Date(s)	Comment(s)

What HAS worked for you in therapy? Describe:

What has NOT worked for you in therapy? Describe:

Over →

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Previous Hospitalizations, Partial Hospitalizations, Day Treatments, CD Treatments, etc

Name/Clinic/Facility	Date(s)	Comment(s)

Have you experienced any significant illnesses, accidents or surgeries? Please describe:

Describe the physical fitness program you follow, if any:

Spiritual/Religious Belief System:

Do you actively participate in a spiritual/faith community? ____ Yes ____ No

If yes, please identify/describe that community:

How important is your faith to you?

What kind of a support system do you have?

Is there anything more that you want to share?

THANK YOU

Signature _____ Date _____

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Making Informed Consent/Agreement to Treatment

Therapy provides you a time and place to feel better, improve yourself, your life, and your relationships. I aim to provide specific intervention techniques and strategies to help you with issues during out sessions and during your everyday life. I will respect you, your values, your story, and your imperfections. I will put your best interests above all else and I will always respect the fact that, at the end of the day, YOU get to make your own decisions about your life.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals and families who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. But, there are no guarantees about what will happen. **Psychotherapy requires a very active effort on your part**. **In order to be most successful, you will have to work on things that we discuss when you leave our sessions.**

Your first appointment will take approximately one hour. During this appointment, you can discuss your situation and concerns with me. After this initial appointment, a formal recommendation for treatment will be discussed. It is possible we will discuss referrals for other services that may be helpful in addition to or in place of therapy: e.g., psychological evaluation, psychiatric evaluation, chemical health evaluation/treatment, intensive outpatient program (IOP), hospitalization, etc.

FINANCIAL RESPONSIBILITY

I prefer payment at time of service. I will bill your insurance; however, **please note: I am an out-of-network provider. It is your responsibility to understand your insurance coverage, deductible, out-of-pocket-max, etc.** If insurance covers a portion of your fee, you will be responsible for the remaining balance. Typically, your insurance company will reimburse you directly. You will be notified if I am reimbursed from your insurance provider and you will see this amount deducted from your overall balance.

Business Services

- Most therapeutic sessions will be 50-60 minutes in length. Longer sessions may be advisable based on the need and therapeutic methods being used
- Clients are asked to pay for each session at the time of service if insurance is not being used
- For questions regarding scheduling, billing, and payment, please speak with your therapist
- Phone consultations with the therapist that exceed 20 minutes in length can be billed
- You are expected to be here for each session that you schedule. The regular fee will be charged for sessions that are missed or cancelled without 24 hour notice, within reason.

Insurance companies typically require a formal diagnosis with their claims. Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (abbreviated as *DSM-5*) There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable/appropriate.

CONFIDENTIAL INFORMATION

Information you furnish to me is confidential according to the Minnesota Access to Health Records Statute. This means that only you and restricted, authorized personnel have access to information in your medical chart. No treatment information will be released to persons, schools, or agencies without your consent, except by court order. If you choose to give your permission, be sure that you understand what information will be released and how it will be used. You may revoke this permission in writing at any time. I will generally ask you to sign releases of information so I can ensure I am doing my due diligence in getting to know you. This may prompt me to communicate with your primary care physician, psychiatrist, a previous therapist or provider, hospitalization records, etc.

There are, however, several exceptions in which I am legally bound to take action even though that requires revealing some information about a client's treatment. If at all possible, I will make every attempt to inform you when these will have to be put into effect. The legal exceptions to confidentiality include, but are not limited, to the following:

1. If there is reason to believe you are threatening serious bodily harm to yourself or others. If I believe a client is threatening serious bodily harm to another, I may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens harm to him/herself or another, I may be required to seek hospitalization for the client, or to contact family members or others who can provide protection.
2. If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, I am required by law to file a report with the appropriate state agency.
3. In response to a court order or where otherwise required by law
4. To the extent necessary for emergency medical care to be rendered.

*In accordance with MN Statutes 144.294 RECORDS RELATING TO MENTAL HEALTH, a minor does have the right to refuse the release of their records to a parent/legal guardian. This refusal may or may not be granted, based what is deemed to be in the best interest of the client and/or family.

As a client, you have the right to:

- Courteous and respectful treatment
- A safe and comfortable environment
- Appropriate behavioral healthcare
- A clear explanation of your diagnosis and treatment plan
- Privacy and confidentiality
- Participate in the planning of your care
- Refuse behavioral health treatment
- Be free from discrimination based on of race, gender, class, religion, sexual orientation, disability, or other aspects of what we look like or where we come from
- Register complaints
- Access to your records as provided by law/policy

You are asked to:

- Ask questions about your care
- Tell your therapist everything you can about your condition, including all symptoms, medications, and past medical history
- Pay your balance in a timely manner
- Keep appointments, or give at least 24 hour notice if you need to cancel or reschedule your appointment
- Let your therapist know about any changes in your symptoms, medications, or general condition
- Treat clinic property with care

ENDING THERAPY

You have the right to take a break from your therapy at any time without permission or agreement. Therapists are ethically required to continue therapeutic relationships with clients only so long as it is reasonably clear that patients are benefiting from the relationship.

If you are unhappy with what is happening in therapy, I hope you'll talk with me so that I can respond to your concerns. Your feedback will be taken seriously and with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspect of the therapy and about my specific training and experience. You have the right to expect that I will not have any type of relationship with my client(s), outside of therapy.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in the office during normal business hours, I do not answer the phone when I am with a client. If you need to contact me between sessions, please leave a message for me at 612-798-7373 ext. 15. I check my messages each day unless I am out of town. If I am planning on being out of town, I will let you know in advance, if this seems appropriate. For emergency situations, call 911 or Crisis Connection at 612-379-6363 {toll free at 1-866-379-6363} or go to your nearest emergency room.

My signature indicates that I have read, discussed, and understand this information.

Client Signature _____ Date _____

Legal Guard Signature (if client is minor) _____ Date _____

LAKEWOOD COUNSELING and Career Center

II *6607 18th Avenue South, Suite #101 Richfield, MN 55423* II *lakewoodcounseling.com* II *(P) 612-798-7373 (F) 612-243-3615* II

Consent to Use/Disclose Healthcare Information for Treatment, Payment, or Healthcare Operations

This notice describes how Psychological and Medical information about you may be used and disclosed. Please review it carefully.

By signing this statement, I understand that as a part of my healthcare, Lakewood originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning my care and treatment
- A means of communication for the various health professionals who may contribute to my care
- A source of information for applying my diagnosis to my bill
- A means by which third-party payers can verify that services were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that as part of Lakewood's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, *if* I consent to such disclosure for these permitted uses, including disclosures via fax.

I wish to have the following restrictions of the use or disclosure of my health information:

_____

_____

(please list any descriptions – use separate page if necessary)

I fully understand and accept the terms of this consent:

_____ _____

Client/Parent/Legal Guardian Signature Date

I understand and have access to a *Notice of Information Practices* (located in the lobby) that provides a more complete description of all information uses and disclosures. I fully understand and accept the terms listed in that document, including my rights and privileges as a client of Lakewood Counseling.

_____ _____

Client/Parent/Legal Guardian Signature Date

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ELECTRONIC COMMUNICATION POLICY

E-Mail Communications

Please be aware that e-mail is *not* a confidential means of communication. I cannot ensure that e-mail messages will be received or responded to immediately. E-mail is not the appropriate way to communicate confidential information or emergency issues. If you e-mail me you are accepting the risks inherent to this form of communication.

Please do not use e-mail for lengthy and complicated medical questions that should properly be addressed via consultation. I will try to reply to your e-mail in a timely manner, however my responses may be delayed over weekends, holidays, or due to technical difficulties. Please be aware that your e-mail communication may become part of your medical record. Please note that e-mail systems may be insecure or unprotected, other members of your household or your employer may have access to your communication via e-mail, therefore it should not be considered private.

Please be sure to include your full name in all communication. All information contained in e-mail messages is intended solely for the addressee unless otherwise explicitly stated and may contain information that is confidential, privileged, or otherwise protected from disclosure under applicable law. If you are an unintended recipient of any e-mail message originating from myself, you are hereby notified that you have received this document in error and that any review, distribution, or copying of this transmission is strictly prohibited. If you have received an e-mail communication in error, please notify me immediately by calling me and leaving a voicemail and destroy all copies on your system.

Text Communications

Text messaging is a very insecure and impersonal mode of communication. I use text communication only with your permission and only for setting and changing appointments unless we have made another agreement. Please do not text me about clinical matters. If you need to discuss a clinical matter with me, please call me so that we can discuss it over the phone or wait so that we can discuss it during your therapy session.

I have read the above information and understand the inherent risks involved if I decide to communicate electronically my therapist.

Signature of patient _____ Date _____

Signature of parent/legal guardian (if necessary) _____ Date _____

(rev. Jan 2016)

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Client Information Form

Date: _____ Therapist: **Jake Lehrer, LMFT**

Client's Legal Name: _____ Client's DOB: _____

Client's Primary Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ (C) _____ (W) _____
please, only provide #'s if we have permission to use* *list 2nd address on backside, if applicable

How did you hear about Lakewood Counseling?: _____

Billing Information:

Responsible Person(s) (Guarantor): _____ Relationship to Client: _____

Guarantor's DOB: _____

Guarantor's Billing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ (C) _____ (W) _____
please, only provide if we have permission to use

Insurance Information: ***Only Provide If You Wish For Your Sessions To Be Submitted To Insurance***
***Please note that Lakewood Counseling and Career Center is an "Out of Network Provider". We will electronically bill the insurance company that you provide. Any insurance payments or denials are ultimately your responsibility to track. Any questions on insurance coverage, eligibility or payments should be directed to your insurance.**

Name of Insurance Company: _____

Client/ Insured's ID #: _____ Group/Policy Number: _____

Mailing Address (on back of card): _____

Policyholder's Name: _____ Relationship to Client: _____

Policyholder's DOB: _____

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Payment Agreement

Cancelled appointments require at least 24 hour notice. In the case of a cancellation without at least 24 hour notice, a missed appointment, or a late arrival, you will generally be charged for the appointment. Insurance companies will not pay for appointments that are cancelled or missed.

The agreed upon for fee for clinical services is as follows:

60 Minute Session: $175.00

Other: _____

***A $20.00 service charge will be added for returned checks. The clinic reserves the right to use a collection agency or conciliation court on accounts 60 days past due.

PLEASE PROVIDE THE REQUESTED CREDIT CARD INFORMATION BELOW. THIS WILL BE USED IF YOU HAVE NOT DISCUSSED A REASONABLE PAYMENT PLAN WITH YOUR THERAPIST AND YOUR ACCOUNT BALANCE GOES UNPAID FOR MORE THAN 60 DAYS.

Type of Credit Card _____(Visa, MasterCard, American Express, Discover)

Name(s) on Card _____

Billing Address _____

Credit Card Number _____

Card Security Code (CVV) _____ Expiration Date _____

I understand and agree to the above conditions:

_____ _____

Signature - Client and/or Parent/Legal Guardian and/or Cardholder **Date**

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AUTO CREDIT CARD PAYMENTS (*_optional_)

I hereby authorize Lakewood Counseling & Career Center to use the following credit card information for payment of future sessions (after the session is completed). I understand that I will be charged for missed appointments if I do not give Lakewood Counseling & Career Center twenty four (24) hour notice, within reason.

This method of payment is most helpful if insurance is not being used for therapy and/or if you have a large deductible that you need to reach before your insurance will reimburse you for therapy.

☐ *USE THE SAME INFORMATION I PROVIDED ON 'PAYMENT AGREEMENT' FORM

Type of Credit Card _____(Visa, MasterCard, American Express, Discover)

Name(s) on Card _____

Billing Address _____

Credit Card Number _____

Card Security Code (CVV) _____ Expiration Date _____

I understand and agree to the above conditions:

_____ _____

Cardholder's Signature **Date**

(rev. Jan 2016)

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Parent Intake Form

Date: ________________ Therapist: ______________________

Child/Adolescent's Name: ___________________________ Age: ______ Date of Birth: _____________

Main purpose for contacting Lakewood Counseling (please give a brief summary):

____
____
____
____

(check one) ☐ biological ☐ step ☐ foster ☐ legal guardian ☐ other _________________
Parent's Name: ___________________________________ Occupation: ____________________
Address: ____ (H) ___________________________
(C) ______________________ (W) _______________________ (e-mail) __________________________

(check one) ☐ biological ☐ step ☐ foster ☐ legal guardian ☐ other _________________
Parent's Name: ___________________________________ Occupation: ____________________
Address: ____ (H) ___________________________
(C) ______________________ (W) _______________________ (e-mail) __________________________

(check one) ☐ biological ☐ step ☐ foster ☐ legal guardian ☐ other _________________
Parent's Name: ___________________________________ Occupation: ____________________
Address: ____ (H) ___________________________
(C) ______________________ (W) _______________________ (e-mail) __________________________

(check one) ☐ biological ☐ step ☐ foster ☐ legal guardian ☐ other _________________
Parent's Name: ___________________________________ Occupation: ____________________
Address: ____ (H) ___________________________
(C) ______________________ (W) _______________________ (e-mail) __________________________

Parent's relationship: Married ______ Divorced ______ Never Married_____ Committed Partners_____
State of Relationship ____
Who has physical custody? _______________________Legal Custody?____________________________

Adolescent lives with which parents: Both equally: _______ Primarily with: _____________
Explain:

____
____

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Siblings: ***(check one)***

Name	Age	Biological	Adopted	Step	Foster	Lives With You?

If adopted, please note significant aspects of the adoption:

_____

_____

_____

What birth family information was/is available?:

_____

_____

_____

Medical Information

Name of Child's Physician: _____ Phone:# _____

Name of Clinic: _____

Date and Reason of Last Physical Exam _____

Current Medication(s)

Name	Dosage	Prescriber/Clinic	Date(s)

**If medication(s) not taken regularly/correctly, please explain:

Previous Medication(s)

Name	Dosage	Prescriber/Clinic	Date(s)

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Previous Therapist(s)

Name/Clinic	Date(s)	Comment(s)

Previous Hospitalizations, Partial Hospitalizations, Day Treatments, CD Treatments, etc

Name/Clinic/Facility	Date(s)	Comment(s)

Current medical problem(s):

_____
_____
_____

Any childhood/developmental concerns:

_____
_____
_____

What things are important to address with your child in therapy?

_____
_____
_____

What do you hope your child gets out of therapy?

_____
_____
_____
_____

What are the strengths of your child?

_____
_____
_____

What methods have you used to discipline your child? Note whether or not effective:

Has your child ever experienced **physical abuse**? If yes, explain and note whether or not it was reported to a mandated reporter (teacher, therapist, doctor, etc.) and/or authorities:

Has your child ever experienced **sexual abuse**? If yes, explain and note whether or not it was reported to a mandated reporter (teacher, therapist, doctor, etc.) and/or authorities:

Has your child ever experienced **psychological/emotional abuse?** (e.g., verbal abuse and constant criticism, intimidation, manipulation, refusal to ever be pleased). If yes, explain and note whether or not it was reported to a mandated reporter (teacher, therapist, doctor, etc.) and/or authorities:
:

Has your child ever experienced **neglect** by a caregiver? If yes, explain and note whether or not it was reported to a mandated reporter (teacher, therapist, doctor, etc.) and/or authorities:

Do you have any concerns related to suicide for your child? (e.g., threats, notes, attempts, self-harm):

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Has your child ever talked about or physically hurt an animal or another person?

Are there areas of concern about your child's school experience?

What are the stressors in your adolescent's life? i.e., family death, illness, financial issues, divorce, change in school, social issues, etc.

Would doing family therapy be helpful in addition to your child/adolescent's individual therapy? How? What issues would YOU address in family therapy?

Is there any other information you would like to share?

THANK YOU

Person Completing Form: _____

Signature _____ Date _____