Confidential Client Questionnaire

Child & Adolescent Intake Form. This questionnaire provides us with important information about your child's medical, family and developmental history. Your answers are strictly confidential.

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Please return completed forms using the secure method provided by your therapist. Do not send completed intake forms by ordinary email unless your therapist has specifically provided a secure encrypted method.

GENERAL INFORMATION: CHILD / TEEN

Child/Teen Name

Today's Date

Date of Birth

Cell phone (if any)

Email (if any)

OPTIONAL: GENDER, PRONOUNS, ORIENTATION, RACE & ETHNICITY

The questions in this section are optional. Answer only what you are comfortable sharing, and select "Prefer not to answer" for anything you would rather skip.

Gender Identity (optional)

Preferred Pronouns (optional)

Sexual Orientation (optional)

☐ Prefer not to answer

Race (select all that apply):

☐ American Indian/Alaska Native ☐ Black and/or African American ☐ White/Caucasian ☐ Asian Indian
☐ Chinese ☐ Korean ☐ Filipino ☐ Japanese ☐ Vietnamese ☐ Native Hawaiian
☐ Guamanian or Chamorro ☐ Samoan ☐ Some other race, ethnicity, or origin ☐ Prefer not to answer

Race - other (optional)

Ethnicity (select all that apply):

☐ Not of Hispanic, Latino/a/x, or Spanish origin ☐ Mexican, Mexican American, Chicano/a/x ☐ Puerto Rican
☐ Cuban ☐ Another Hispanic, Latino/a/x or Spanish origin ☐ Some other race, ethnicity, or origin
☐ Prefer not to answer

Ethnicity - other (optional)

PARENT / GUARDIAN INFORMATION

Parent / Guardian (1)

Name

Relationship to Child

Cell phone

Email

Street Address

City

State

Zip

Parent / Guardian (2)

Name

Relationship to Child

Cell phone

Email

Street Address

City

State

Zip

- [ ] I grant the clinician permission to identify themselves when calling the patient/parent
- [ ] I grant the clinician permission to email me regarding scheduling
- [ ] The clinician's office staff may contact me regarding billing and scheduling

EMERGENCY CONTACT

Emergency Contact Name

Relationship to Child

Contact's Phone

CURRENT SCHOOL INFORMATION

Name of School

Grade

Name of Teacher

Teacher Phone / Email

REFERRAL SOURCE

Did anyone refer you? ☐ Yes ☐ No

Name of referrer

How did you hear about us?

AREAS OF CONCERN: PARENT / GUARDIAN

What issues or concerns cause you to seek treatment for your child at this time?

Do you have any specific goals with regard to your child's treatment?

Do you have any particular concerns or fears with regard to your child's treatment?

AREAS OF CONCERN: CHILD / TEEN

What issues or concerns cause you to seek treatment at this time?

Do you have any specific goals with regard to your treatment?

Do you have any particular concerns or fears with regard to your treatment?

CHILD'S STRENGTHS

	Often True	Sometimes True	Seldom True	Cannot Say
Outgoing	☐	☐	☐	☐
Self-confident	☐	☐	☐	☐
Seems happy	☐	☐	☐	☐
Friendly	☐	☐	☐	☐
Enjoys new experiences or activities	☐	☐	☐	☐
Even disposition or steady moods	☐	☐	☐	☐
Expresses feelings	☐	☐	☐	☐
Affectionate	☐	☐	☐	☐

Kind or sympathetic to others	☐	☐	☐	☐
Shares	☐	☐	☐	☐
Can compromise	☐	☐	☐	☐
Follows rules easily	☐	☐	☐	☐
Is forgiving	☐	☐	☐	☐
Stands up for self when appropriate	☐	☐	☐	☐
Tolerates criticism	☐	☐	☐	☐
Recovers easily after disappointment	☐	☐	☐	☐
Is appropriately cautious	☐	☐	☐	☐
Creative	☐	☐	☐	☐
Plays appropriately with smaller children and animals	☐	☐	☐	☐
Good sense of humor	☐	☐	☐	☐

Other strengths:

INTERNET / ELECTRONIC COMMUNICATION USAGE

Do you have any concerns with your child using the Internet? ☐ Yes ☐ No ☐ N/A

If yes, please describe.

Do you have any concerns with your child's electronic communications (e.g. Facebook, Snapchat, texting, TikTok, Instagram)? ☐ Yes ☐ No ☐ N/A

If yes, please describe.

Do you have any concerns with your child's video game usage? ☐ Yes ☐ No ☐ N/A

If yes, please describe.

PREVIOUS TREATMENT

Has client ever received mental health treatment before? ☐ Yes ☐ No

If yes, when and for how long?

If yes, what was the focus of treatment?

Has client ever been diagnosed with an eating disorder? ☐ Yes ☐ No

If yes, what and when?

If yes, what are client's beliefs, perceptions, attitudes, and behaviors regarding food?

Is client in recovery for addiction or compulsion, or is there any history of substance use? ☐ Yes ☐ No

If yes, please describe (including any program, sobriety date, or current status).

SAFETY HISTORY

If you are in immediate danger or thinking about harming yourself, call or text 988 (Suicide & Crisis Lifeline) or dial 911. Your therapist will review any safety concerns with you.

Has client ever attempted suicide? ☐ Yes ☐ No

If yes, when?

Did the attempt require medical attention? ☐ Yes ☐ No ☐ N/A

Did client receive inpatient treatment following the attempt? ☐ Yes ☐ No ☐ N/A

If yes, please describe the circumstances that led to that attempt.

Is client currently having any suicidal thoughts? ☐ Yes ☐ No

If yes, please describe.

In the past, has client ever had suicidal thoughts? ☐ Yes ☐ No

If yes, please describe.

FAMILY MEDICAL HISTORY

Check any illness or condition or condition that any member of the immediate family (i.e., brothers, sisters, aunts, uncles, cousins, grandparents) has had, and note that family member's relationship to the child on the line below the condition.

- ☐ Seizures or Epilepsy
- ☐ Neurological illness/disease
- ☐ Attention deficit
- ☐ Mental illness
- ☐ Hyperactivity
- ☐ Depression or anxiety
- ☐ Learning disabilities
- ☐ Tics or Tourette's syndrome
- ☐ Intellectual disability
- ☐ Alcohol or drug abuse
- ☐ Childhood behavior problems
- ☐ Suicide attempt

FAMILY INFORMATION

Please list all of the significant parental figures involved in the child's life:

Name	Relationship to Child	Age	Gender	Occupation

Parents are currently: ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Other

If other, please describe

Child's legal guardian is

Sibling Information:

Name	Relationship to Child	Age	Gender	Currently at home? (Y/N)	Any learning or behavioral challenges?

Have there been any deaths or separations from caregivers, family members, babysitters, or friends with whom your child had close contact? If yes, please explain and include dates of separation/loss:

MEDICAL INFORMATION

Medical Doctor

Date of last physical exam (approx.)

How would you rate the client's physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Psychiatrist

Other Specialist

Please list any psychiatric medication your child has taken or is taking:

Medication	Date	Benefits / Side Effects

Describe any current physical problems or concerns that client has:

List any history of significant physical problems (e.g. broken bones, head injury, surgery):

Is or has client ever been overly sensitive to (check all that apply):

☐ Touch (e.g. tags in clothing, wet diapers, textures) ☐ Smells (e.g. perfumes, etc.)

☐ Sights (e.g. lights, different colors, other visual stimuli) ☐ Tastes ☐ Noises (e.g. vacuum, telephone ring, etc.)

PAYMENT INFORMATION

Please provide a credit card authorization regardless of your payment method.

Credit Card Authorization: I, _____ (printed name)

authorize the maintenance of valid credit card information to guarantee my chosen payment option.

Cardholder Name _____

Card Type ☐ Visa ☐ MC ☐ Discover ☐ AmEx

Billing Address _____ City _____ Zip _____

Credit/Debit Card Number _____ Expiration Date _____ CVV / Security Code _____

Cardholder/Client Signature _____ Date _____

Therapist Name _____

Payment is due when services are rendered. If payment is not made when services are rendered, or if you have an outstanding balance, then your credit card on file will be charged in the amount of the outstanding balance. Monthly statements will be provided upon request via a HIPAA secure email or U.S. mail. Clients are responsible for submitting all claims to their insurance provider.

Payment Guarantee: I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fail to make payment promptly when due, I will promptly pay on demand. If I commit to group therapy, I understand that the weekly fee for group sessions is due even if I do not attend.

I understand there is a 24-hour cancellation policy and that I will be charged without providing 24 hours advance notice to cancel a session.

I have read, understand and agree to the information, authorization and guarantee stated above.

Client Signature _____ Printed Name _____ Date _____

CONSENT FOR TREATMENT AND OFFICE POLICY

This consent is to certify that you give permission to your therapist at Menachem Psychotherapy Group to provide psychotherapy treatment. You have a right to terminate the therapeutic relationship at any time without fault.

MINOR CONSENT TO TREATMENT

Psychotherapy can be a very important resource for children. Establishing a therapeutic alliance outside of the home can:

- Facilitate open and appropriate expression of strong feelings such as guilt, grief, sadness and anger.
- Provide an emotionally neutral setting in which children can explore these feelings.
- Help children understand, accept, and cope with whatever difficulty they may be experiencing.
- Offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities.

However, the usefulness of therapy may be limited when the therapy itself becomes simply another matter of dispute between parent and child or between parents. With this in mind, and in order to best help your child, we strongly recommend that your child and each of the child's caregivers (e.g., parents or stepparents) mutually accept the following as requisites to participation in therapy.

As your child's psychotherapist at Menachem Psychotherapy Group, it is our primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important

others (e.g., pediatrician, teachers). In some cases, this may include a recommendation that you consult with a physician, should matters of your child's physical health be relevant to this therapy.

NON-DISCRIMINATION POLICY

The Menachem Psychotherapy Group respects each person's right to choose their own belief system. It is the policy of The Menachem Psychotherapy Group not to discriminate against any individual on the basis of race, color, religion, ancestry, national origin, citizenship status, age, sex, marital status, genetic information, sexual orientation, gender expression, gender identity, non-disqualifying disability or veteran/military status. While our gender, ethnicity, orientation or spirituality may be different, we are open to discussing any concerns or questions you may have in working with a therapist who is either a different race, religion, orientation or gender than you. If you have any questions regarding our therapeutic approach and style, or our non-discrimination policies, please feel free to discuss this with us now and/or in the future.

CONFIDENTIALITY

Please be advised regarding the limits of confidentiality as it applies to psychotherapy with a child:

- When we treat minors, the parent(s) or guardian(s) who have consented to treatment, have a right to access information regarding the treatment. But as children grow into adolescence, we believe the importance of the therapeutic relationship requires confidentiality between client and therapist; Parents or guardians have the right to general information, such as information on how therapy is going, but the details in therapy will be treated as confidential, unless it is a matter of safety.
- In cases where we treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. We may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes, any limits on confidentiality that may exist, and our role.
- In the case of separation or divorce, any matter brought to our attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to our attention that are irrelevant to the child's welfare may be kept in confidence. However, these matters may best be brought to the attention of others, such as attorneys, personal therapists or counselors.
- We are legally obligated to bring any concern regarding the child's health and safety to the attention of relevant authorities. When possible, should this necessity arise, we will advise all parties regarding our concerns.

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by the child and the parent, after signing a release of information, to convey information to a third party. However, there are specific exceptions to this policy:

- When there is a reasonable suspicion of child abuse, dependent-adult or elder abuse.
- When a client threatens violence to an identifiable victim.
- When a client presents a danger of violence to others.
- When a client is likely to harm him/herself unless protective measures are taken.

Disclosure may also be required in certain legal proceedings. If you have concerns about the content of our sessions and any legal proceedings in which you are involved or expect to be involved, please let your therapist know. Before such disclosure is made, every reasonable effort will be made to appropriately resolve these issues and to notify clients.

CONTACTING THERAPISTS

Clients may text, email, or leave a voicemail for your therapist at any time. Please be aware that therapists may not retrieve or respond to messages until their regular office hours. If you have a life-threatening emergency, dial 911.

APPOINTMENTS

Typically, sessions are 50 minutes in length and begin at the scheduled appointment time (unless another length of time is agreed upon with your therapist). If you arrive late, your session will be shorter and will end at its normal time. If your therapist begins session late, your session will be extended to make up the time. If you need to cancel a session, please let your therapist know at least 24 hours in advance. You will be responsible for the full fee of any session

canceled with less than 24-hour notice. You will be responsible for the full fee of any session that is not attended without notice of cancellation within 24 hours.

CONJOINT SESSIONS

If it benefits the client's therapy goals, we may occasionally ask that a family member or significant other join us for a conjoint therapy session. If the client would like to include a family member or significant other for a conjoint therapy session this will be done only on occasion and at the therapist's discretion (when it best serves the client). Please note that the family member or significant other is not joining the session for their own therapy, nor will we work with them as a therapist. If we decide that this would be beneficial, you will need to sign a written release of information for this type of conjoint session.

SOBRIETY POLICY

The Menachem Psychotherapy Group asks that all clients arrive to therapy sober and not under the influence of illegal drugs and/or alcohol. If we notice that you are intoxicated we will immediately end the therapy session, and assist you in finding a safe ride home as driving while under the influence constitutes a risk to others and is a reportable offense. We will reschedule the therapy session where we will process this occurrence. You will be charged your full fee for the session if you arrive intoxicated.

FEES, BILLING & PAYMENTS

All services are billed at the standard rate agreed upon with your therapist. Sliding-scale fees may be established based on ability to pay and therapist availability. Payment is due when services are rendered, unless other arrangements have been made. Please notify your therapist if any problems arise that affect your ability to make timely payments.

If document preparation is required (e.g. legal proceedings, insurance appeals), clinicians reserve the right to bill for services, plus fees for materials (copies, outside services, etc).

In order to prevent any misunderstandings about payment for services, please be advised of the following:

(1) All services provided are billed directly to the client unless other arrangements have been made.

(2) Clients are personally responsible for payment at time of service.

(3) Superbill statements can be provided for you to submit for insurance reimbursement.

(4) You are responsible for submitting all claims to your insurance provider.

(5) If payment cannot be processed and you have made no other payment arrangements, your past due balance may be sent to an agency for collection.

Payment Guarantee: You are individually responsible for all incurred charges, even if you direct us to bill another person. If you direct charges to be billed to another person, you represent that you are authorized to give such direction. If you have directed charges to be billed to another person who fails to make payment, you will promptly pay on demand.

I have read, understand, and agree to the information, guidelines and office policies stated above:

Client (if 12 or older)

Signature _____ Printed Name _____ Date _____

Parent / Legal Guardian (1)

Signature _____ Printed Name _____ Date _____

Parent / Legal Guardian (2)

Signature _____ Printed Name _____ Date _____

Therapist Name _____ Date _____