ADOLESCENT INTAKE FORM

Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before the first therapy session.

Adolescent, please fill out pages 1-3. Parent/guardian, please fill out pages 4-9

CLIENT INFORMATION

Name:_____

Date of Birth:_____ Age: _____ Gender:_____

Phone(cell):_____ Can we leave message at this number?

School: _____ Grade: _____

CURRENT REASON FOR SEEKING THERAPY

Why are you coming to therapy?

_____

_____

How do you think therapy might help you?

_____

_____

PERSONAL STRENGTHS

What activities do you enjoy?

_____

_____

What qualities are you proud to share with others? (e.g. kindness, intelligence…)

_____

_____

THERAPY/TREATMENT HISTORY

Have you previously seen a therapist? ☐ Yes ☐ No

If yes, what did you find **most helpful** in therapy?

_____

_____

If yes, what did you find **least helpful** in therapy?

_____

_____

SUBSTANCE USE AND HISTORY

Do you currently use alcohol? ☐ Yes ☐ No

If yes, how **often** do you drink? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

If yes, how **much** do you drink? _____ (#) per time

Do you currently use tobacco? ☐ Yes ☐ No

If yes, how **often** do you smoke/chew? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Do you currently use any other drugs? ☐ Yes ☐ No
If yes, how **often** do you use? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

FAMILY INFORMATION
Are your parents married, divorced or separated? _____
Do you think their relationship is good? ☐ Yes ☐ No ☐ Unsure
If your parents are divorced, whom do you primarily live with? _____
Were you adopted? ☐ Yes ☐ No

FAMILY CONCERNS *Please check any family concerns that your family is currently experiencing*
☐ Fighting ☐ Disagreeing about relatives ☐ Feeling distant ☐ Disagreeing about friends
☐ Loss of fun ☐ Alcohol use ☐ Lack of honesty ☐ Drug use ☐ Physical fights
☐ Education problems ☐ Divorce/separation ☐ Financial problems
☐ Issues regarding remarriage ☐ Death of a family member ☐ Birth of a sibling ☐ Abuse/neglect
☐ Birth of a child ☐ Inadequate housing
Other concerns not listed above: _____

_____

PEER RELATIONS
How do you consider yourself socially? ☐ Outgoing ☐ Shy ☐ Depends on the situation
Are you happy with the amount of friends you have? ☐ Yes ☐ No
Have you ever been bullied? ☐ Yes ☐ No
If yes, please descibe: _____

_____

Are your parents happy with your friends? ☐ Yes ☐ No
Are you involved in any organized social activites? (e.g. sports, music)? _____

_____

SCHOOL HISTORY
On a scale of 1-10 (10 being the most) how much do you enjoy school? _____
Do you attend regularly? ☐ Yes ☐ No
Generall, how are your grades? _____
Have there been any significant changes in your grades? ☐ Yes ☐ No
Do you feel you are doing the best you can at school? ☐ Yes ☐ No ☐ Unsure

INDIVIDUAL CONCERNS
Is there anything else you would like to share? _____

_____

_____

_____

Please place a checkmark in the appropriate box for each of the following that you might be feeling:

Symptom	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS					SOCIAL ISOLATION				
CRYING					PARANOID THOUGHTS				
PROBLEMS AT HOME					INDECISIVENESS				
HYPERACTIVIY					LOW ENERGY				
BINGING/PURGING					EXCESSIVE WORRY				
LONELINESS					POOR CONCENTRATION				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/INDIGESTION					IDENTITY QUESTIONS				
SOCIAL ANXIETY					HALLUCINATIONS				
SELF HARM/CUTTING					RACING THOUGHTS				
IMPULSIVITY					RESTLESSNESS				
NIGHTMARES					DRUG USE				
HOPELESSNESS					ALCOHOL USE				
ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
ANOREXIA					OBSESSIVE THOUGHTS				
GRIEF					PANIC ATTACKS				
PHOBIAS					FEELING ANXIOUS				
HEADACHES					FEELING PANICKY				
CHANGE IN WEIGHT					SUICIDAL THOUGHTS				
CHANGE IN APPETITE					HOMICIDAL THOUGHTS				
DIFFICULTY SLEEPING					OTHER				

ADOLESCENT INTAKE FORM
PARENT SECTION

Parent(s) Name(s): _____
Parent(s) Phone Number(s): _____
Adolescent's Name: _____ Date of Birth: _____
Race/Ethnic Orgin: _____

PRESENTING ISSUES
Briefly describe the presenting issue(s) for which you are seeking therapy for you adolescent.

_____

_____

What would you like to see happen as a result of therapy? _____

_____

_____

What is most concerning right now? _____

_____

_____

CHILD'S DEVELOPMENT
Were there any complications with the prenancy or delivery of your child? ☐ Yes ☐ No
If yes, please describe: _____

_____

Did your child have health problems at birth? ☐ Yes ☐ No
If yes, please describe: _____

_____

Has your child experience and developmental delays (e.g. toilet training, walking, talking)?
☐ Yes ☐ No ☐ Unsure *If yes, please describe:* _____

_____

_____

Did you child display any developmentally unusal behaviors or problems prior to age 3?
☐ Yes ☐ No ☐ Unsure *If yes, please describe:* _____

_____

_____

Has your child experienced emotional, physical, or sexual trauma? ☐ Yes ☐ No ☐ Unsure
If yes, please describe: _____

_____

_____

TREATMENT/MEDICAL HISTORY

Has your child previously seen a therapist? ☐ Yes ☐ No

If yes, where:

Approximate dates and counseling:_____

For what reason(s) did you child attend therapy?_____

Has your child access psychiatric services? ☐ Yes ☐ No

*If yes, where:*_____

Has your child been treated at a higher level of care for mental health reasons? (e.g. inpatient, residential, partial, intensive outpaitent program) ☐ Yes ☐ No

Does your child have a previous mental health diagnosis? ☐ Yes ☐ No ☐Unsure

*If yes, please specify:*_____

_____

What did you find **most helpful** about their treatment?_____

_____

_____

What did you find **least helpful** about their treatment?_____

_____

_____

Has your child taken medication for a **mental health** concern? ☐ Yes ☐ No

*If yes, please indicate names, dosages, and dates:*_____

_____

_____

Does your child have other **medical** concerns or previous hospitalizations? ☐ Yes ☐ No

*If yes, please describe:*_____

_____

_____

SUBSTANCE USE

Do you have any concerns with your child using alcohol or drugs? ☐ Yes ☐ No

*If yes, please explain your concern:*_____

_____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your child using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting ect? ☐ Yes ☐ No

*If yes, please explain your concern:*_____

_____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you, your family, or your child (at present, or have had a significant effect in the past) _____

_____

_____

SCHOOL HISTORY

Do you have any current concerns relating to your child's education? ☐ Yes ☐ No

If yes, pease explain your concern: _____

_____

_____

Does your child receive special education services through their school system? ☐ Yes ☐ No

☐ IEP ☐ 504 Plan ☐ Speech ☐ OT ☐ PT

FAMILY HISTORY

Did either parent experience any abuse/trauma as a **child** in their home (physical, verbal, emotional, or sexual) or outside your home? *Please describe as much as you feel comfortbable.*

_____

_____

_____

Did either parent experience any abuse/trauma in their **adult** life (physical, verbal, emotional, or sexual)? *Please describe as much as you feel comfortable.*

_____

_____

_____

Please list all of the people in what you would describe as your immediate family:

NAME	RELATIONSHIP TO CHILD	AGE	GENDER	TYPE(BIO, STEP, OR ADOPTIVE	LIVING WITH CHILD? Y/N

PARENT'S MARITAL STATUS *(This question regers to the parents relationship. Please answer the following as best as you can, we understand that you my not be able to answer some of the questions pertaining to the other parent, if applicale.)*

☐ Single ☐ Married*(legally)* ☐ Divorced ☐ Co-habitating ☐ Divorce in process ☐ Separated
☐ Windowed ☐ Remarried *(mother)* ☐ Remarried *(father)* ☐ Other
Length of marriage/relationship: _____
If divorced, how old was your child at the time of divorce?_____

Parent's Name: _____ **Birth Date:** _____ **Age:** _____
Ethnic Orgin: _____
Occupation: _____ Place of Employment: _____
Military experience? ☐ Yes ☐ No
Current Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Windowed ☐ Other
Assessment of current relationship if applicable: ☐ Poor ☐ Fair ☐ Good

Parent's Name: _____ **Birth Date:** _____ **Age:** _____
Ethnic Orgin: _____
Occupation: _____ Place of Employment: _____
Military experience? ☐ Yes ☐ No
Current Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Windowed ☐ Other
Assessment of current relationship if applicable: ☐ Poor ☐ Fair ☐ Good

Please note any custody concerns/arrangements if applicable:

_____

_____

FAMILY MENTAL HEALTH HISTORY
In this sectin below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child (e.g. father, maternal grandmother, uncle, etc.)

☐ Alcohol/substance abuse ☐ Anxiety ☐ Depression ☐ Domestic Violence ☐ Eating disorders
☐ Obsessive compulsive behavior ☐ Major mental illness ☐ Suicide attempts
☐ Psychiatric hospitalizations ☐ Other
List family member(s):_____

FAMILY CONCERN(S) *(Please check any family concerns that your family is <u>currently</u> experiencing)*
☐ Fighting ☐ Disagreeing about relatives ☐ Feeling distant ☐ Disagreeing about friends
☐ Loss of fun ☐ Alcohol use ☐ Lack of honesty ☐ Drug use ☐ Physical fights ☐ Education problems ☐ Divorce/separation ☐ Financial problems ☐ Issues regarding remarriage
☐ Death of a family member ☐ Birth of a sibling ☐ Abuse/neglect ☐ Birth of a child
☐ Inadequate housing
*Other concerns not listed above:*_____

_____

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your child enjoys?

What positive personal qualities does your child have?

Who are some of the influential and supportive people, activites or beliefs in your child's life?
Please describe:

Is there anything else you would like to share?

Please place a checkmark in the appropriate box for each of the following symptoms that is affecting your adolescent:

Symptom	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS					SOCIAL ISOLATION				
CRYING					PARANOID THOUGHTS				
PROBLEMS AT HOME					INDECISIVENESS				
HYPERACTIVIY					LOW ENERGY				
BINGING/PURGING					EXCESSIVE WORRY				
LONELINESS					POOR CONCENTRATION				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/INDIGESTION					IDENTITY QUESTIONS				
SOCIAL ANXIETY					HALLUCINATIONS				
SELF HARM/CUTTING					RACING THOUGHTS				
IMPULSIVITY					RESTLESSNESS				
NIGHTMARES					DRUG USE				
HOPELESSNESS					ALCOHOL USE				
ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
ANOREXIA					OBSESSIVE THOUGHTS				
GRIEF					PANIC ATTACKS				
PHOBIAS					FEELING ANXIOUS				
HEADACHES					FEELING PANICKY				
CHANGE IN WEIGHT					SUICIDAL THOUGHTS				
CHANGE IN APPETITE					HOMICIDAL THOUGHTS				
DIFFICULTY SLEEPING					OTHER				

Disclosures and Informed Consent

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Clinical Mental Health Counselor, Evergreen Pediatrics
505 NE 87th Ave. Suite 120 I Vancouver, WA 98664
Phone: 360-892-1635 I Direct (text): 971-249-2028
cepstein@evergreenpeds.com

The following information is provided to help you determine if what I offer as a mental health counselor meets your needs as a client. This document contains important information about my therapeutic approach, my education, and your rights as a client including your rights regarding your private health information. Please read this document carefully and ask any questions that help you fully understand the content of this disclosure statement and agreement for services.

Nature of Treatment: (i) Evaluation and treatment planning: approximately 1-3 sessions, (ii) Intervention: depends on many factors, such as the nature of your child's difficulties and readiness for change, (iii) Termination: Approximately 1-2 session, involves a "toolbox" of strategies that may be used to help your child maintain treatment gains and reduce the likelihood of relapse and/or recurrence. Treatment effectiveness varies from person to person. Discussing, working with, and changing thoughts, feelings, and behaviors may be painful and challenging at times.

Confidentiality: Your participation in therapy, the content of our sessions, and any information you provide to me I protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

- If you give me written consent to have the information released to another party.
- With your authorization, to effect billing of a third-party payor for the services I provide to you.
- In the case of your death or disability I may disclose information to your personal representative.
- If you waive confidentiality by bringing legal action against me.
- In response to a valid subpoena from a court or from the secretary of the Washington State Department of Health for records, related to a complaint, report, or investigation.
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other person.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05. If you have any questions regarding your confidentiality, the limits of confidentiality, or the exceptions to confidentiality, please let me know. I will be happy to discuss this with you further.

Mutual rights and Responsibilities: The relationship must remain limited to a respectful therapeutic framework. You/your child may refuse any therapeutic suggestions offered, or to suspend or cease treatment at any time without penalty. ***If you decide to stop treatment for any reason, please notify your therapist so that the file can be closed and/or a referral can be made to another resource. If you stop treatment without explanation the file will automatically be closed after 30 days.***

Please note that while I provide therapy services to children and families with a wide variety of needs, I do not provide parent mediation services and do not take part in the creation of parenting plans. I do not make or inform custody arrangements.

My role is as your child's therapist; it is out of my scope to provide other services to your child or family. This means that I do not provide or take part in: parent mediation services, creation of parenting plans, making or informing custody arrangements, or speaking to the court with recommendation on these topics. Evaluations of parental competency or child placement are out of my scope of practice.

Supervision and Consultation: I seek ongoing supervision and consultation from colleagues to provide you with the best services possible. I may disclose information about you in consultation with colleagues, in which case I will limit the information I disclose to the minimum amount necessary.

My Education, Training, and Experience: I am a Licensed Mental Health Counselor Associate regulated by Washington State (License Number 61387201). My supervisor is Lacey Meehan, LMFT. I received a master's degree in Clinical Mental Health Counseling from Northwestern University, Evanston, Illinois and a bachelor's degree in Fine Art from Hamilton College in Clinton, New York.

Therapeutic Orientation and Practice Modality: My foundational clinical orientation encompasses a neurodivergent affirming and trauma-informed approach. Modalities that I embrace are ACT, psychodynamic theory, child-centered play theory and Adlerian theory where each case is addressed with a trauma-informed, neurological, and interpersonal lens.

I have undergone extensive DBT training, EMDR, MEMI, TF-CBT and neurodivergent affirming care training. I have worked with a variety of clients in volunteer work in the disabled community, children in dependency programs and the LGBTQ+ community. I am a member of the AMCA, ACA, The Association for Play Therapy, and the Academy for Eating Disorders. I strive to be culturally sensitive in all of my modalities.

Working with Minors: If you are the parent or guardian of a minor who is seeking treatment, please know that under Washington State law, and child aged 13 or older can independently consent to mental health treatment without your permission. In addition, parents or guardians may not generally access the treatment record of a client aged 13 or older without that client's written permission. If you are 13 years of age or older, you have the legal right to seek mental health treatment without obtaining permission from a parent or guardian. Under certain circumstances, the parent of an adolescent may consent, on behalf of the adolescent, to a mental health or substance use assessment and limited treatment.

I am not able to provide a recommendation, evaluation, or opinion, in any legal forum relating to separation, divorce, child custody, visitation, or parenting plans. For children under age 13, I will need to be provided with a copy of any parenting plan, custody orders, or any other similar documents, including any changes or revision made during the course of treatment. It is generally necessary that both parents or legal guardians consent to the treatment of their minor child.

Electronic Communications and Social Media Policy: In order to best protect your confidentiality, I typically will communicate with clients via email or text message for the purpose of scheduling or canceling appointments only. I cannot guarantee the security or confidentiality of information sent via email or text. If you need to communicate with me via email or text for any other purpose, please discuss that with me in person. While I am generally able to respond to email and text communications from clients within 48 hours Monday-Friday, at times there may be a longer delay in responding.

To respect your confidentiality and to protect against inconsistent dual relationships, I will not follow clients on social media, nor can I accept requests to follow me personally on personal social media. I do maintain a professional social media presence that I may use to provide general information to clients. Please do not use any professional social media platform as a mode of direct communication with me. In addition, please understand that your decision to connect to my professional social media presence may result in the disclosure of our professional relationship.

Emergencies: If you are experiencing an emergency or crisis, please call 911 or the National Crisis line at 988. In such situations, you may also go to the nearest hospital emergency room.

State of Washington Disclosures: The State of Washington requires that I provide you with the following information. As an individual, you have the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits your needs. Counselors practicing counseling for a fee must be credentialed or licensed with the Department of Health does not include a recognition of any practice standards, not necessarily imply the effectiveness of any treatment.
A copy of the acts of unprofessional conduct can be found in RCW 18.13.180. Complains about unprofessional conduct can be made to:

Health Systems Quality Assurance Complain Intake Post Office Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
E-mail: HSQAComplaintIntake@doh.wa.gov

Consent for Treatment: By signing this document, you are attesting that you have received, red, fully understand, and consent to the disclosures, terms, and conditions above, that you have received a copy of your HIPAA Notice or Privacy Practice, have ready and fully understand these rights, and have been given the opportunity to ask questions.

By signing this document, you are attesting to your consent to participation in counseling services provider by Catherine Haley Epstein, MA, LMHCA Evergreen Pediatric Clinic, under supervision by Lace Meehan, LMFT, license: 60270965

Name of child/client: _____ **Today's Date:** _____

Name of parent/guardian: _____ **Signature:** _____

Name of parent/guardian: _____ **Signature:** _____