evergreen pediatric clinic

CHILD THERAPY INTAKE FORM
Please complete on behalf of your child

Name of person completing this form:_____

Your relation to the child:_____

Phone:_____ Email:_____

Name of another parent/legal guardian:_____

Phone:_____ Email:_____

Child's first name:_____

Age:_____ Birth day:_____ Month:_____Year:_____

Ethnicity:_____ Religion:_____ Sex/gender:_____

Home address:_____

Who does your child live with?_____

ACEDEMIC INFORMATION:

Name of child's school:_____ Grade/year:_____

Program:_____ Typical grades:_____

THE REASONS FOR YOUR CHILD'S VISIT:_____

_____

_____

_____

_____

_____

How intense is your child's emotional distress?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please describe:_____

_____

_____

Overall, how much do the problems affect your child's ability to perform, get along with others, and perform daily tasks such as chores?

(Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)

Please describe:_____

_____

_____

_____

When did these problems start? What was going on in your child life at that time?

_____

_____

_____

_____

_____

_____

_____

PSYCHIATRIC AND MEDICAL HISTORY

Please list and ***psychiatric or "mental"*** problems your child has been diagnosed with:

_____

_____

_____

_____

_____

_____

Please list any **medical or *"physical"*** problems that your child has been diagnosed with:_____

_____

_____

_____

_____

Please list any **medications your child takes,** and what they are taken for:

_____

_____

_____

_____

_____

Name of **Family doctor:**_____ Phone:_____

Last check-up was during the month of:_____Year:_____

Results:_____

_____

_____

_____

Name of **Psychiatrist:**_____ Phone:_____

Last visit was during the month of:_____Year:_____

Results:_____

_____

_____

_____

_____

MENTAL HEALTH TREATMENT HISTORY

Has your child been hospitalized for psychological/psychiatric reasons? ☐Yes ☐ No
If yes, please describe when and where, and for which reasons.

_____

_____

_____

Please tell us about any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

_____

_____

_____

CURRENT HABITS

Please describe your child's ***current*** **habits** in each of the following areas:

Smoking: _____

Drinking: _____

Drug use: _____

TV use: _____

Internet use: _____

Video game use: _____

Caffeine intake: _____

Exercise: _____

Eating: _____

Sleeping: _____

Fun and relaxation: _____

Chores and responsibilities: _____

RELATIONSHIPS
Please describe your child's relationship with each of the following people, if applicable:

Biological Mothing:_____

Biological Father:_____

Step-parents: _____

Legal Guardians:_____

Siblings:_____

Extended family:_____

Your children: _____

Friends: _____

Romantic partners:_____

Colleagues or classmates:_____

Total number of close, supportive relationships:_____

STRESSFUL LIFE EVENTS
Please describe any significant or stressful life events that your child has been experiencing:

	No	Yes	If yes, please describe
A recent move or change in school?			
Abuse or neglect?			
Bullied or ignored by peers?			
Academic difficulties			
Weight control issues?			
Sexual orientation concerns?			
Self-injury?			
Death or illness of a loved one or pet			
Family conflict			
Separation or divorce?			
Other?			

Is there anything else that you would like to mention?

_____

_____

What are your child's positive qualities and skills? What do you like about your child? What qualities have helped your child to succeed at overcoming difficulties in the past? _____

_____

_____

_____

Please tell us about your child's interests (sports, hobbies, talents, etc.)

_____

_____

_____

Does your child agree that the problem that she or he is seeking help for is problematic? _____

_____

_____

_____

What are some goals for your child's therapy? What would you like them to achieve by attending therapy? _____

_____

_____

_____

_____

What concerns do you have about your child attending therapy or working on these problems? _____

_____

_____

_____

_____

_____

Disclosures and Informed Consent

Catherine Epstein, MA, LMHCA
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:** _____