Empowerment THERAPY CENTER
Phone: (833) ETC-LIFE
Email: info@empowermentmail.com
9720 Capital Ct, Suite 303
Manassas, VA 20110

# Child / Adolescent Client Intake Packet

Name: _____ DOB: _____ Date of first appointment: _____
Parent/Guardian (1) Name:_____ Parent/Guardian (2) Name:_____

**Describe Guardianship/Custody Agreement (A legal guardian must be present at the intake assessment)**

_____

Please take your time in providing the following information. The questions are designed to help me begin to understand your child so that our time together can be as productive as possible.
**All information provided is confidential**.

**Referred by:**
__Medical Provider: _____
__Insurance Provider: _____
__My Website: https://empowerment-therapy-center.com/ PsychologyToday
__Friend/Family: _____
__Other: _____

**Has the patient previously received any type of mental health services?** __Yes __No
If yes, which of the following?:
__Psychotherapy __Medication __Outpatient __Hospitalizations __Inpatient Hospitalization

**If yes, please provide:**
Name of provider or facility:_____
Location:_____
Dates of treatment:_____
Reason for treatment:_____

**Briefly, what brings your child in today?**

**When did the problem first start?** Within the last: __30 days __6--12 months __2 years __During adolescence __During childhood

**What areas of your child's life have been affected because of this problem?**

**Is your child currently experiencing overwhelming sadness, grief or depression?** __Yes __No
If yes, for approximately how long? _____
***Any Suicidal Thoughts?**__ Current? __Past? – How long ago?_____ Notes:_____

**Is your child currently experiencing anxiety, panic attacks or have any phobias?** __Yes __No
If yes, when did your child begin experiencing this? _____

***Any History of self-harm?** __Current? __Past? – How long ago?_____ Notes:_____
_____

***Any thoughts about harming others?** __Current? __Past? – How long ago? _____ Notes:_____
_____
_____

**Please describe any major losses or traumas your child has experienced:**

**What significant life changes or stressful events has your child experienced recently?**

**What would you like to see accomplished during your child's time in therapy?**

## Family History

Where was the patient born? _____ Where did the patient grow up? _____ __City __Suburbs __Country

Please list the patient's **parents, step-parents, siblings, and any other significant family members**.
Please use additional space on the back if needed.

| Name | Age | Relationship | Where do they live now? | If deceased, age and cause of death |
|---|---|---|---|---|
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Who has the patient lived with throughout their childhood?_____
Mother's occupation: _____Father's occupation? _____

**In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc).**

| Condition | Please Circle | List Family Member |
|---|---|---|
| Alcohol/ Substance Abuse | Yes / No | |
| Anxiety | Yes / No | |
| Depression | Yes / No | |
| Domestic Violence | Yes / No | |
| Sexual Abuse | Yes / No | |
| Eating Disorders | Yes / No | |
| Obesity | Yes / No | |
| Obsessive Compulsive Disorder | Yes / No | |
| Schizophrenia | Yes / No | |
| Suicide Attempts | Yes / No | |
| Other diagnosed mental health condition? | Yes / No: Which was?: | |

**Guardians' Marital Status:**

Primary Guardian #1 (PG#1) / Primary Guardian#2 (PG#2)

PG#1 / PG#2

__ __ Never Married

__ __ Domestic Partner

__ __ Married

**If married, how long have you been married, and what is your partner's name:

(PG#1)_____ (PG#2)_____

__ __ Separated

__ __ Divorced -- For how long? _____

__ __ Widowed: Please provide your partners name and year deceased: (PG#1 or PG#2?-Circle)

_____

*Parent(s) currently in a romantic relationship?

__ __ Yes -- How long? (PG#1)_____ (PG#2)_____

__ __ No

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What is the patient's Gender?_____ Preferred pronoun(s)?_____

What is the patient's Sexual Orientation?_____

Any issues related to gender or sexual orientation that might be relevant to treatment?

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## Physical Health

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Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If your child has a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your child's health.

| Medication/Supplement | Dosage | Condition | Date Began/Stopped |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Prescribing provider(s) and contact information:**
Name: _____
Specialty: _____
Facility: _____
Phone, email, or Fax: _____

**How would you rate the patient's current physical health?**
__Poor __Unsatisfactory __Satisfactory __Good __Very Good

**Please list any specific and significant health problems the patient is currently experiencing:**

**How would the patient rate their current sleeping habits?**
__Poor __Unsatisfactory __Satisfactory __Good __Very Good

**If the patient is having problems, in which phase of sleep are they experiencing issues?**
__Falling asleep __Staying asleep __Awakening early __Sleep apnea

**Please list any other specific sleep problems the patient is currently experiencing:**

How many times per week does the patient generally exercise? _____ What types of exercise does the patient participate in?:

Is the patient currently experiencing any chronic pain? __No __Yes If yes, please describe:

## Substance Use/ Abuse

**Please describe <u>current</u> use of alcohol, cigarettes, and/or recreational drugs:**

**Please describe <u>previous</u> use of alcohol, cigarettes, and/or recreational drugs:**

## Additional Information

**Describe the patient's strengths and limitations related to education:**

**Is there an IEP/504 Plan?** __Yes __No
**Describe the patient's social relationships:**

**What does the patient enjoy doing in their free time? What do they do to relax?**

**Is the patient spiritual or religious? If yes, please describe their faith or belief:**

**What are some of the patient's strengths?**

**What are some of the patient's weaknesses?**

**Any additional Information that might help your child's clinician better understand your child's unique circumstances:**

**Reviewed by (Therapist/Supervisor):** _____ _____ _____

Print Signed Date

*See biopsychosocial assessment for additional notes*

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# Patient Acknowledgement

## Receipt of Patient Agreement

**Please sign, print your name, and date this acknowledgement form.**

By signing below, I hereby acknowledge that I have been provided with the *Empowerment Therapy Center's* (ETC's) ***Patient Agreement***. The *Patient Agreement* is available at any time on the ETC website located at:

http://empowerment-therapy-center.com

I may also obtain a copy from my ETC therapist upon request, or by ETC, or may access a copy for review in the ETC waiting room. The Patient Agreement includes explanations of the following:

**Consent for Treatment**

**Notice of Privacy Practices**

**Financial Policy**

**General Office Policies**

"I (Guardian, if patient is a minor)_____have read in full, have been provided adequate opportunity to clarify any questions, understand, and agree to the Empowerment Therapy Center's **Patient Agreement**. I also understand that the Patient Agreement may be modified without notice. I will discuss these policies with my (or the child's) therapist, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services."

Patient/ (or guardian if minor) Signature:

_____

Patient Name: _____ Guardian (if minor) Name:

_____

Witness Signature:_____ Date: _____Patient DOB:_____

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## RELEASE OF MEDICAL INFORMATION

Date of Release_____

Dear Dr._____(Primary Care Physician),

We are currently working with your patient, _____, (DOB:_____) in outpatient mental health counseling. Many insurance carriers require that health information on clients must be obtained. In order to fulfill this requirement, we must request that you either mail or fax the client's latest physical health information.

Our mailing address is: Empowerment Therapy Center, etc, PLLC
9720 Capital Ct, Suite 303
Manassas, VA 20110

Our fax number is: 833-382-5433

Thank you for your prompt attention and your cooperation in this matter. Below you will find the signatures of the client/ guardian indicating agreement with this release.

_____ _____
Signature of Client/Guardian Date

_____ _____
Signature of Staff Witnessing Date

Date Sent to PCP: _____

*Clinician: Please complete this form and either fax or mail a copy of this form to the above-mentioned doctor. Scan this completed form with the date sent in the client's chart.*

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## GENERAL RELEASE OF INFORMATION

CLIENT NAME: _____ DOB _____ Date of Release: _____

I hereby give my written permission for *Empowerment Therapy Center, etc* to exchange the following verbal or written information as indicated with:
_____ (Name or Entity).

Extent or nature of use/disclosure is limited to: (Check or list all that apply)

__ Discharge Summary __ History & Physical __ Psychiatric Evaluation __ Progress notes

__ Medical Records __ Lab Work __ Consultations __ Treatment Plan

__ School Records __ Psychological Evaluation __ Case Coordination __ Medication Management

__ Diagnostic Information __ Treatment Recommendations

__Other:_____
_____
__

Date and/or condition when release will expire: _____

If not specified, the release will expire one year from the date signed or 30 days from discharge, if this occurs before one year.

*As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose, and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations, or eligibility are not conditional upon giving authorization. The original, or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. The authorization is automatically revoked upon termination of service.

The person who receives the records to which this authorization pertains may not redisclose them to anyone else without my separate written authorization unless such recipient is a provider who makes a disclosure permitted by law. A general authorization for the release of medical or other information is not sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or federal law protect the disclosed confidential information. Federal regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Signature (parent signature if client is a minor)
_____Date:_____

Staff Witnessing Signature_____Date:_____

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## CONFIDENTIAL

## CREDIT CARD INFORMATION FORM

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Name of Client:_____

Name of Card Holder (as it appears on card):_____

VISA__ MASTERCARD__ DISCOVER__ AMEX__ (HSA cards are fine)

Credit Card #_____ Exp Date:_____
CCV:_____

Zip code associated with this card (billing zip):_____

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**I, _____, authorize *Empowerment Therapy Center,* to charge this card for:**

**__ copayment(s)/ co-insurance(s) due, or**

**__for a one-time payment in the amount of: $_____**

**Signature:_____ Date:_____**