CHILD/ADOLESCENT INTAKE

Barbara L. Riste, MBA, MA, LPC
19753 East Pikes Peak Court, Suite 201 Parker, CO 80138
Phone: 303,841.0259
Email: parkercounselinginc@gmail.com
Website: www.parkercounselinginc.com

PLEASE PRINT CLEARLY

Date _____

Name of Child _____

DOB _____

Is there a primary address of Child or Adolescent? _____

If yes, Primary Address of Child _____

City _____Zip Code _____State _____

Parent(s) phone: Cell(s)_____ _____
Home _____

Email Address of Adolescent age 15 years or older _____

Cell phone of Adolescent age 15 years or older _____

School _____

Grade _____

Marital Status of Parent: Married, Separated, Divorced, Never Married

If parents are living separately, please list address, home phone, work phone and cell phone:

Mother's Information **

Mother's Name _____

Home Phone _____Cell Phone_____
Work Phone _____

Address _____

City _____Zip Code _____State _____

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** IT IS IMPORTANT TO HAVE CORRECT CONTACT INFORMATION FOR THE PARENT/GUARDIAN OF YOUR CHILD. ISSUES SUCH AS CLINICAL CONCERNS, EMERGENCY CONTACT OR INCLEMENT WEATHER NEED TO BE COMMUNICATED AS EFFICIENTLY AS POSSIBLE.

Father's Information **

Father's Name _____

Address _____

City _____Zip Code _____State_____

Email Address _____

Home Phone _____Cell Phone _____Work Phone _____

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List any special academic concerns you may have about your child _____

_____

_____

List all individuals living in the household (if divorced, list individuals living in each household)

Mother's Household

Name Relationship to Child

_____

_____

_____

_____

_____

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Father's Household

Name Relationship to Child

_____

_____

_____

Presenting Issues:

Briefly describe your concerns or issues with your child _____

_____

_____

_____

How long has this been a concern of yours? _____

When was this first noticed? _____

Does anything seem to help the problem? _____

_____

Has your child received an evaluation or treatment for this issue or for a similar issue? _____

If yes, when and with whom? _____

Family History:
Place a check next to any illness or condition that any member of your family has had. (Please include both the mother's and father's family of origin as well, e.g. grandmothers, uncles, aunts, cousins, etc.) Please note the relationship of the family member to your child.

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Mother's Family of Origin

If yes, please check below	Condition _____	Relationship to Child _____
	Depression	
	Anxiety	
	Bipolar	
	Other psychological issues	
	Alcoholism	
	Drug Abuse	

Father's Family of Origin

If yes, please check below	Condition _____	Relationship to Child _____
	Depression	
	Anxiety	
	Bipolar	
	Other psychological issues	
	Alcoholism	
	Drug Abuse	

Is there any other family history information you feel may be pertinent?

_____

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What are your child's or adolescent's favorite activities?

1. _____
2. _____
3. _____
4. _____

Has your child or adolescent ever been in trouble with the law? _____If yes, please describe briefly.

_____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check by each technique that you use.

For children age 12 years or less:

	Ignore the problem		Tell the child to sit in a chair
	Scold the child		Use a time-out
	Spank the child		Send the child to his/her room
	Threaten the child		Take away some activity or food
	Reason with the child		Don't use any technique
	Redirect the child's interests		Child does not require discipline

For adolescents:

	Ignore the problem		Ground Teenager
	Scold the adolescent		Send the adolescent to his/her room
	Spank the adolescent		Restrict Favorite activities or items

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	Threaten the adolescent		Don't use any technique
	Reason with the adolescent		Adolescent does not require discipline

Child's or Adolescent's Medical History:

Child's/Adolescent's Physician

_____

Date of last physical: _____

Were there any abnormal findings or information you think may be helpful for your child in therapy?

_____

Current medications:

_____

Medical conditions:

_____

Does your child complain of frequent headaches, stomachaches or fatigue? _____

_____

Social and Behavioral Information:

Please place a check next to any behavior or problem your child has:

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	Has difficulty with speech		Engages in self-mutilating or destructive behaviors
	Has difficulty with hearing		Has special fears, habits or mannerisms
	Has difficulty with vision		Wets the bed
	Has difficulty with coordination		Has poor bowel control
	Prefers to be alone		Bites nails
	Does not get along well with brothers or sisters		Has frequent tantrums
	Does not get along well with peers at school, day-care setting, pre-school, etc.		Has frequent nightmares
	Is aggressive		Has difficulty sleeping
	Is shy or timid		Holds breath
	Is more interested in things than in people		Engages in dangerous behavior
	Eats poorly		Is stubborn
	Is clumsy		Crave any certain type of food
	Show daredevil behavior		Is slow to learn
	Gives up easily		Sucks thumb

Educational History:

Place a check next to any educational issues(s) your child exhibits:

	Has difficulty with reading		Has difficulty with writing
	Has difficulty with mathematics		Does not like school
	Has difficulty with spelling		Has difficulty with other subjects

If any, list other subjects here:

_____

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Does your child have any special needs, for example IEP? _____

_____

Has your child ever received special tutoring or therapy in school? If yes, please describe. _____

_____

Does your child have a cell phone? _____
If so, is there parental supervision? _____
Is your child on social media? _____

Developmental History:

During pregnancy, was mother on medication? If so, what kind of medication? _____

_____

During pregnancy did mother smoke cigarettes? If yes, how many per day? _____

During pregnancy, did mother drink alcohol or use drugs? If yes, what did she use and how much was approximately consumed?

_____

_____

Were there any birth defects or complications? _____

Were there any special problems in the growth and development of the child during the first few years?

_____

Is there any other information you feel would be pertinent and helpful while working with your child? _____

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Referral:

Were you referred here and if so, please list below?

Physician or Therapist _____

Friend _____

Current or former client _____

Online search _____-

DISCLOSURE INFORMATION

My practice is regulated by the Colorado State Department of Regulatory Agencies. Please let me know if you are dissatisfied with my services. If I am unable to resolve your concerns, you may report your concerns to:

State Grievance Board
1560 Broadway Street #1340
Denver, Colorado 80202
303-894-7766
Or
National Board of Certified Counselors
Greensboro, North Carolina
910-547-0607

You are entitled to know my credentials:

M.A., Counseling Psychology, University of Colorado at Denver
M.B.A. Finance, University of Colorado
B.A. History/Pre-law, Colorado State University

License: Licensed Professional Counselor #2167
Registration: National Board of Certified Counselors

You are entitled to be informed about the methods of psychotherapy, the duration (if known) and the fees for my services. Unless otherwise specified, psychotherapy sessions for individuals are 50 minutes in length and sessions for couples and families are 100 minutes in length.

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There are conditions that may lie beyond my areas of expertise. In such situations, I will provide referrals to professionals capable of treating such conditions.

You may seek a second opinion from another mental health or medical professional at any time. You may terminate psychotherapy at any time.

Our relationship is a professional one. In such a relationship, sexual intimacy is never appropriate and should be reported to the Colorado State Grievance Board if it occurs.

The confidentiality of information you provide me in my capacity as a therapist is protected by law; this includes the fact that you have sought my services. Exceptions are delineated in the attached document and will be discussed with you should the need arise.

All communication (including email, fax, etc.) is inclusive in clinical records. This information is accessible to the client upon request.

Please be aware I am not a crisis counselor. I am not on call 24 hours a day and do not work Saturdays and Sundays. If you are in a crisis situation, please go to your closest hospital emergency room or call 911. Phone calls and emails are generally returned within 24 hours during business hours of 8 am to 5 pm Monday through Friday.

Fees:

The fee for a fifty-minute session is $175 per session. The fee for a 100-minute family session is $350 per session. Fees are due and payable at time of session. Cash, personal checks, credit cards, HSA accounts, FSA accounts and PayPal are accepted. Please note there is a $5 additional charge for credit cards and Paypal. A 21% interest rate is applied to any thirty day past due balances. There will be a $35 charge for any returned check.

The session fee applies to other services including but not limited to emails, phone calls, and insurance reports. If I am requested to work with third parties including but not limited to CFI, PRE or attorneys the fee is $300 per hour charged in fifteen minute increments. This includes time for research, reports, forms, etc. I DO NOT TESTIFY IN COURT. I will provide a synopsis of my records upon request.

Cancellations:

Please review Client Cancellation and No-Show policy for further details on advance notice of cancellations so as not to incur additional fees.

Insurance:

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Insurance coverage and reimbursement are the client's responsibility. Since payment for session is required at time rendered, any subsequent reimburse from the insurance company should be sent directly to the client. Please do not assign payment to me. It will delay the reimbursement process. You are still responsible for payment in full should treatment and treatment recommendations exceed third-party reimbursement.

I have read and understand the above statements regarding my rights as a client and the procedures and policies disclosed.

Client (or parent of minor) _____ Date _____

Barbara L. Riste, MBA, MA, LPC

CONFIDENTIALITY

All information is confidential **with the following exceptions**. This is not an exhaustive list of instances in which confidentiality may not be honored.

- If there is evidence that a person is gravely disabled or poses an imminent threat to self or others, the therapist can legally take measures to ensure the safety of the individual and others.

- The Colorado Children's Code mandates a therapist must report any suspected or known child abuse (includes emotional, sexual or physical abuse).

- Clients who are minors (under 18 years of age) have limited rights of confidentiality. Professional judgment regarding what is disclosed to the client's parents will be exercised. Typically, the minor will be involved in the decision regarding the sharing of information with the parents or informed of the rationale for sharing information against her/his wishes.

- A client may be asked to sign an authorization permitting the therapist to communicate with another party. The purpose of such communication will be discussed before the release is requested. The

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highest degree of professionalism is maintained in such communications. The client has the right to refuse to authorize any release of information and to specify what information may be released.

- Insurance companies require a clinical diagnosis and sometimes other clinical information in order to process payment of claims.

- The use of fax, email, cellular phones and other electronic media pose special risks to the confidentiality of communication. All sent and received emails will be printed and filed in the client's file. Upon specific request, a specified type of electronic media will not be used for communication of confidential information.

- Non-response to repeated requests for payment of service may be given to an agency for collection purposes.

- The confidentiality of information you provide me in my capacity as a therapist is protected by HIPAA. This includes both electronic and written records. Records include name, phone numbers, home address, email addresses, possible diagnosis and clinical notes.

- If I contract with administrative or technical support vendors, they are required to protect the confidentiality of your personal health information to the same extent as Parker Counseling, Inc.

I have read and I understand the above statements regarding the exceptions to confidentiality. I agree to the confidentiality exceptions.

_____

Client (or parent of minor) Date

_____

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Client Cancellation and No-Show Agreement

I understand that situations arise in which you must cancel your appointment. Please provide notice as soon as you realize you cannot keep your appointed time. This allows me to have the opportunity to schedule someone else. A fee could apply if not enough notice is given for a cancellation. Below is an explanation for notices needed to avoid fees for cancellations and no-shows.

- **24 HOURS WORKDAY (MONDAY – FRIDAY) NOTICE** IS NEEDED FOR AN **INDIVIDUAL** 50 MINUTE SESSION CANCELLATION

- **48 HOURS WORKDAY (MONDAY – FRIDAY) NOTICE** IS NEEDED FOR **COUPLES** HOUR AND 40 MINUTE SESSION CANCELLATION

Fees are the same as the individual or couple's appointment fee.

The cancellation and no-show fees are the sole responsibility of the client and must be paid in full before the client's next appointment. I understand that emergencies and illnesses arise, and the fees may be waived in those situations.

A beneficial and respectful therapeutic relationship is based on understanding and clear communication.

Please sign that you have read, understand and agree to this cancellation and no-show agreement.

Please print name _____

Signature of client or responsible party _____

Date _____

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Permission to Charge Credit Card

In the event of a late cancellation or no show, I give permission to Barbara Riste to charge my credit card the fee for the missed individual or couple's appointment.

Name of person responsible for payment: _____

Name as it appears on credit card if different from above: _____

Type of card:

American Express ____
Discover _____
Visa _____
Mastercard _____

Credit Card Number:

_____
Expiration Date: ____/____(mm/yy)
Security Code (CVV): _____

Billing address associated with card:
Street: _____
City: _____State: _____
Zip Code: _____

I give permission to Barbara L. Riste, MBA, MA, LPC to charge my credit card for professional services. Barbara Riste agrees to only charge for the services rendered or late cancellations/no-show sessions if the appointment is not canceled per the Client Cancellation and No-Show Agreement.

I understand that I have the right to revoke this agreement at any time by providing a request in writing.

Signature: _____

Date: _____