# CHILD INTAKE FORM

*Please complete on behalf of your child*

## Child's Info

Name:_____ Age:_____ DOB:_____

Male_____ Female_____ Grade: _____ Typical Grades: _____

## Legal Guardian Info

Parent/Legal Guardian 1

Name: _____ Relation to child: _____

Phone:_____ Email:_____

Parent/Legal Guardian 2

Name: _____ Relation to child: _____

Phone:_____ Email:_____

Does the child live with both parents? Y / N

If no, please explain legal custody agreement concerning decision making:

_____

_____

**What is the reasoning for your visit today?**

_____

_____

_____

**What do you hope your child receives from counseling?**

_____

_____

**How intense is your child's emotional distress?**

(mild) 1 2 3 4 5 6 7 8 9 10 (severe)

**If any, how much does this affect your child's ability to perform in school, get along with others, and perform daily tasks?**

(mild) 1 2 3 4 5 6 7 8 9 10 (severe)

**When did these problems start? Where there any identifiable triggers at that time?**

_____
_____
_____
_____
_____

## Medical History

If any, please list any medical problems and the date your child was diagnosed:

_____
_____
_____

If any, please list any psychiatric diagnoses and the date the child was diagnosed:

_____
_____
_____

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

_____
_____
_____

## Family Mental Health History

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 (e.g. father, grandmother, uncle, etc.)

| | **Please Circle** | **List Family Member** |
|---|---|---|
| Alcohol/Substance Abuse | yes / no | _____ |
| Anxiety | yes / no | _____ |
| Depression | yes / no | _____ |
| Domestic Violence | yes / no | _____ |
| Eating Disorders | yes / no | _____ |
| Obesity | yes / no | _____ |
| Obsessive Compulsive Behavior | yes / no | _____ |
| Schizophrenia | yes / no | _____ |
| Suicide Attempts | yes / no | _____ |

# Disclosure Statement

## Brittany Junker

## Mental Health Counselor Intern

Training and professional background:

Brittany Miller has a master's degree in Clinical Mental Health Counseling from Hodge's University in Fort Myers Florida. Brittany is a Registered Mental Health Counselor Intern with the State of Florida. She is under the direct supervision of Rebecca Sherry who is a Licensed Mental Health Counselor in the State of Florida#(MH12994). She has experience working with Adults and Children experienced trauma, anxiety, depression, ADHD, conduct disorder, relationship and/or family conflict, domestic violence, sexual violence, self-esteem, mood disorder and grief.

Theoretical orientation and approach to counseling:

Brittany's clinical approach to counseling includes Solution-Focused Brief Therapy, Acceptance and Commitment Therapy, Cognitive Behavioral Therapy, Compassion-Focused Therapy, Emotion-Focused Therapy, Guided Therapeutic Therapy, Holistic Psychology, and Mindfulness-Based Therapy.

The right of clients in counseling:

It is appropriate for clients to raise questions about the counselor, the therapeutic approach, the progress of the therapy and the cost. As informed consumers, it is the client's responsibility to choose the counselor and counseling modality which best suits their needs. Clients have the right to request a change in counseling approach, referral to another counselor or termination at any time.

Brittany Miller is bound by the ethical codes of her of her respective professional organizations, by the laws of the State of Florida, as well as by agency policy regarding the special nature of a therapist-client relationship. It is expected that the counselor will continue to be aware of the influential position they hold in the relationship with clients, using this influence in a constructive way. If a client thinks his/her counselor is not meeting this ethical responsibility, he/she is strongly encouraged to address this with the counselor.

Confidentiality:

Counseling sessions are held in strict confidence. It is the client, not the therapist, who determines whether information may be released to persons outside of this office, and only then, with a release signed by the client. Interns work closely with their supervisor Janean Byrne and will frequently discuss client case details to assure proper therapeutic gains. The counselor may be required to break confidentiality in life-threatening situations where the client poses a clear and present danger to self or others or is unable to provide minimum life sustaining self-care. In these situations, the counselor is required to take steps necessary to secure the safety of the client or others.

My signature below acknowledges that I a m the legal guardian of _____and have received and understand the Disclosure Statement; thus, consenting to their participation in counseling services at Serenity Counseling Center.

Client (or legal guardian's) signature(s) _____ Date _____

Spouse (or other parent) signature _____ Date _____

Mental Health Counselor Intern's Signature _____ Date _____

# Serenity Counseling Center

## Patient Treatment Agreement

Welcome to Serenity Counseling Center. We would like to ensure you that you will receive the best possible care from our professional staff.

**Payment:** Due at the time that the service is provided. We accept credit or debit cards. A 3% fee will be applied to credit or debit transactions. The fee for a 50-minute session is $90.00. As a client, you are agreeing to pay $90 at the end of each session.

**Cancelations:** If you are unable to keep your scheduled appointment, you must notify your counselor 24 hours prior to your appointment or you will be charged a $50.00 cancellation fee. You are giving Serenity Counseling Center permission to contact you via phone call, text or email concerning your appointment, case information or other business pertaining to Serenity Counseling Center.

**Legal:** Our counselors are available for in-office depositions at an agreed upon fee. The counselors are not available, nor will appear in court for testimony regarding a case unless arrangements are made outside of and prior to this initial agreement. By signing you agree that this information has been formally conveyed.

"I, the undersigned, agree to treatment by the providers in this office, and furthermore have read and understand the above policies".

Client Name: _____ Date: _____

Client Signature: _____ Date: _____

# Serenity Counseling Center

Informed Consent for Telehealth Services

I understand that "telehealth" can include secure videoconferencing or other interactive audio, video, or data communications.

In addition, telephone calls or psychoeducation via email may be a reasonable option during this temporary expansion of services.

The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential by my service provider (Serenity Counseling Center), however, because telehealth occurs outside of the therapist's office, I understand I am responsible for taking steps to ensure confidentiality of the sessions in my location by – 1) engaging in telehealth sessions when I am in a private location and have made every effort to maintain my own privacy in that location, and 2) and agreeing not to record any telehealth session or portion of a telehealth session. 4. I understand that there are risks and consequences from telehealth, including but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by unauthorized persons; and/or electronic storage of my medical information could be accessed by unauthorized persons. 5.

I understand that I am responsible for the following: - providing the computer and/or necessary telecommunications equipment and internet or phone access for telehealth sessions. - arranging for a location with appropriate lighting, sound, or other characteristics that will allow telehealth sessions to proceed effectively. I understand that I may benefit from telehealth sessions but that results cannot be guaranteed or assured. I agree to provide my location to my therapist before the telehealth session begins in the event that my therapist has a grave concern about my wellbeing so s/he/they could initiate a wellness check. I agree to be dressed for any telehealth session as if I were attending an in-person, face-to-face session. I understand that services delivered by my therapist are required by law to take place within the state in which my therapist is licensed, with the exception for crisis consultations or sessions. If I am physically located outside of the state in which my therapist is licensed, I will immediately notify my therapist.

My signature indicates that I have read, understand, and agree to everything above:

Printed Name _____ Date: _____

Signature _____ Date: _____