SweetwaterPractice
Counseling & Consulting

# TEEN INTAKE FORM

Teen: Please fill out pages 1-8, read and sign pages 15-22
Parent/guardian: Please fill out pages 9-24

## PATIENT INFORMATION

Name:_____ Date of Birth: _____ Age: _____

Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other:

Ethnicity: _____ Religion:_____

Home Address: _____

_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email: _____

School: _____ Grade: _____

Please share electronic communication that you use (Facebook, Twitter, Snapchat, Instagram, etc.):

_____

Are you currently working with any other practitioners? ☐ Yes ☐ No

If Yes, Name and Address:

_____

## COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ☐ Yes ☐ No

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

_____

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

_____

_____

Major reason for seeking help at this time:

How long have you had these problems or symptoms?

Why did you seek help now?

What goals do you have for therapy?

Have you had any serious accidents, head injuries, or seizures? ☐ Yes ☐ No

If Yes, Dates & Details:

Do you have any recurring nightmares? ☐ Yes ☐ No If yes, describe:

Who loves you unconditionally and supports you in your life?

What is your spirituality?

What spiritual resources do you have, if any? By what name do you call your spiritual supports?

What characteristics do you like most about yourself?

What states of being do you want to live in or return to (peace, joy, creativity, freedom)?

_____

_____

**CHEMICAL 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 much do you smoke/chew? _____

Do you currently use any other drugs? Yes _____ No _____

If yes, what drugs do you use? _____

If yes, how often do you use? _____Daily, _____Weekly, _____Occasionally, _____Rarely

Have you received any previous treatment for chemical use? Yes _____ No _____

If so, where did you go?_____

Adolescents (please answer the following with Y/N)

Have you ever used more than one chemical at the same time to get high? _____

Do you avoid family activities so you can drink or use drugs? _____

Do you have a group of friends who also drink or use drugs? _____

Do you drink or use drugs to improve your emotional state? _____

**FAMILY HISTORY**

Are your parents married or divorced? _____

Do you think their relationship is good? ☐ Yes ☐ No ☐ Unsure

If your parents are divorced, whom do you primarily live with? _____

How often do you see each parent? Mom_____% Dad _____%. 5.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

**FAMILY CONCERNS** *(Please check any concern for you 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 | | Infidelity |
| | Death of a family member | | Divorce/ separation |
| | Financial problems | | Issues regarding remarriage |
| | Abuse/ neglect | | Birth of a sibling |
| | Feeling unsafe | | Birth of a child |
| | Job change or job dissatisfaction | | Other: |

Other concerns not listed: _____

**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

If no, say more: _____

Have you ever been bullied? ☐ Yes ☐ No

If yes, say more: _____

Are your parents happy with your friends? ☐ Yes ☐ No

Are involved in any organized social activities ( e.g. sports, scouts, music)?

_____

**SCHOOL HISTORY**

Do you like school? ☐ Yes ☐ No _____

Do you attend regularly? ☐ Yes ☐ No _____

What are your current grades? _____

Do you feel you are doing the best you can at school? ☐ Yes ☐ No _____

## THE AMEN CLINIC QUESTIONNAIRE

For each item, please describe your experience today or in the past two weeks using the following scale. (0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently)

____ 1. Frequent feelings of nervousness or anxiety
____ 2. Panic attacks
____ 3. Avoidance of places due to fear of having an anxiety attack
____ 4. Symptoms of heightened muscle tension (sore muscles, headaches)
____ 5. Periods of heart pounding, nausea, or dizziness (not w/ exercise)
____ 6. Tendency to predict the worst
____ 7. Multiple, persistent fears or phobias (dying, doing something crazy)
____ 8. Conflict Avoidance
____ 9. Excessive fear of being judged or scrutinized by others
____ 10. Easily startled or tendency to freeze in intense situations
____ 11. Seemingly shy, timid, and easily embarrassed
____ 12. Bites fingernails or picks skin
**____ Total number of questions with a score of 3 or 4 for questions 1- 12**

____ 13. Persistent sad or empty mood
____ 14. Loss of interest or pleasure from activities that are normally fun
____ 15. Restlessness, irritability, or excessive crying
____ 16. Feelings of guilt, worthlessness, helplessness, hopelessness
____ 17. Sleeping too much or too little, or early morning waking
____ 18. Appetite changes/ weight loss or weight gain through overeating
____ 19. Decreased energy, fatigue, feeling "slowed down"
____ 20. Thoughts of death or suicide, or suicide attempts
____ 21. Difficulty concentrating, remembering, making decisions
____ 22. Physical symptoms; headaches, chronic pain, digestive problems
____ 23. Persistent negativity or low self esteem
____ 24. Persistent feeling of dissatisfaction or boredom
**____ Total number of questions with a score of 3 or 4 for questions 13-24**

____ 25. Excessive or senseless worrying
____ 26. Upset when things are out of place or don't go according to plan
____ 27. Tendency to be oppositional or argumentative
____ 28. Tendency to have repetitive negative or anxious thoughts
____ 29. Tendency toward compulsive behaviors
____ 30. Intense dislike of change
____ 31. Tendency to hold grudges
____ 32. Difficulty seeing options in situations
____ 33. Tendency to hold on to own opinion and not listen to others
____ 34. Needing to have things done a certain way or you become upset
____ 35. Others complain you worry too much
____ 36. Tendency to say no without first thinking about the question
**____ Total number of questions with a score of 3 or 4 for questions 25-36**

0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently

____ 37. Periods of abnormally happy, depressed or anxious mood
____ 38. Periods of decreased need for sleep, energetic on much less sleep
____ 39. Periods of grandiose thoughts and ideas (feeling very powerful)
____ 40. Periods of increased talking or pressured speech
____ 41. Periods of too many thoughts racing through your mind
____ 42. Periods of increased energy level
____ 43. Periods of poor judgment that leads to risk-taking behaviors
____ 44. Periods of inappropriate social behavior
____ 45. Periods of irritability or aggression
____ 46. Periods of delusional or psychotic thinking
**____ Total number of questions with a score of 3 or 4 for questions 37 – 46**

____ 47. Short fuse or periods of extreme irritability
____ 48. Periods of rage without being provoked
____ 49. Often misinterprets comments as negative when they are not
____ 50. Periods of spaciness or confusion
____ 51. Periods of panic or fear for no specific reason
____ 52. Visual or auditory changes (seeing shadows or hearing sounds)
____ 53. Frequent periods of déjà vu (feeling you've been somewhere before)
____ 54. Sensitivity or mild paranoia
____ 55. Headaches or abdominal pain or uncertain origin
____ 56. History of head injury or family history of violence/ explosiveness
____ 57. Dark thoughts, may be homicidal or suicidal
____ 58. Periods of forgetfulness or memory problems
**____ Total number of questions with a score of 3 or 4 for questions 47- 58**

____ 59. Trouble staying focused
____ 60. Spaciness or feeling like you're in a fog
____ 61. Overwhelmed by tasks of daily living
____ 62. Feels tired, sluggish, or slow moving
____ 63. Procrastination, failure to finish things
____ 64. Chronic boredom
____ 65. Loses things
____ 66. Easily distracted
____ 67. Forgetful
____ 68. Poor planning skills
____ 69. Difficulty expressing feelings
____ 70. Difficulty expressing empathy for others
**____ Total number of questions with a score of 3 or 4 for questions 59-70**

## MODIFIED HCL-32 QUESTIONNAIRE

**Please try to remember a period when you were in a "high" state. How did you feel then? Please check these statements even if you do not feel that way currently. Please put a check mark by each that have applied in the past or now.**

| | Description | |
|---|---|---|
| 1 | I need less sleep | |
| 2 | I feel more energetic and more active | |
| 3 | I am more self-confident | |
| 4 | I enjoy my work more | |
| 5 | I am more sociable (make more phone calls, go out more) | |
| 6 | I want to travel and/or do travel more | |
| 7 | I tend to drive faster or take more risks when driving | |
| 8 | I spend more money/too much money | |
| 9 | I take more risks in my daily life (in my work and/or other activities) | |
| 10 | I am physically more active (sport etc.) | |
| 11 | I plan more activities or projects. | |
| 12 | I have more ideas, I am more creative | |
| 13 | I am less shy or inhibited | |
| 14 | I wear more colorful and more extravagant clothes/make-up | |
| 15 | I want to meet or actually do meet more people | |
| 16 | I am more interested in sex, and/or have increased sexual desire | |
| 17 | I am more flirtatious and/or am more sexually active | |
| 18 | I talk more | |
| 19 | I think faster | |
| 20 | I make more jokes or puns when I am talking | |
| 21 | I am more easily distracted | |
| 22 | I engage in lots of new things | |
| 23 | My thoughts jump from topic to topic | |
| 24 | I do things more quickly and/or more easily | |
| 25 | I am more impatient and/or get irritable more easily | |
| 26 | I can be exhausting or irritating for others | |
| 27 | I get into more quarrels | |
| 28 | My mood is higher, more optimistic | |
| 29 | I drink more coffee | |
| 30 | I smoke more cigarettes | |
| 31 | I drink more alcohol | |
| 32 | I take more drugs (sedatives, anti-anxiety pills, stimulants | |

## INDIVIDUAL CONCERNS

| SYMPTOM | NONE | MILD | MOD | SEVERE | | SYMPTOM | NONE | MILD | MOD | SEVERE |
|---|---|---|---|---|---|---|---|---|---|---|
| SADNESS | | | | | | APPETITE CHANGES | | | | |
| CRYING | | | | | | SOCIAL ISOLATION | | | | |
| SLEEP DISTRUBANCES | | | | | | PARANOID THOUGHTS | | | | |
| PROBLEMS AT HOME | | | | | | POOR CONCENTRATION | | | | |
| HYPERACTIVITY | | | | | | INDECISIVENESS | | | | |
| BINGING/PURGING | | | | | | LOW ENERGY | | | | |
| LONELINESS | | | | | | EXCESSIVE WORRY | | | | |
| UNRESOLVED GUILT | | | | | | LOW SELF WORTH | | | | |
| IRRITABILITY | | | | | | ANGER ISSUES | | | | |
| NAUSEA/INDIGESTION | | | | | | SPIRITUAL CONCERNS | | | | |
| SOCIAL ANXIETY | | | | | | HALLUCINATIONS | | | | |
| SELF MUTALATION | | | | | | RACING THOUGHTS | | | | |
| CUTTING | | | | | | RESTLESSNESS | | | | |
| IMPULSIVITY | | | | | | DRUG USE | | | | |
| NIGHTMARES | | | | | | ALCOHOL USE | | | | |
| HOPELESSNESS | | | | | | EASILY DISTRACTED | | | | |
| ELEVATED MOOD | | | | | | TRAUMA FLASHBACKS | | | | |
| MOOD SWINGS | | | | | | OBSESSIVE THOUGHTS | | | | |
| DISORGANIZED | | | | | | PANIC ATTACKS | | | | |
| ANOREXIA | | | | | | FEELING ANXIOUS | | | | |
| GRIEF | | | | | | FEELING PANICKY | | | | |
| PHOBIAS | | | | | | SUICIDAL THOUGHTS | | | | |
| HEADACHES | | | | | | PAST SUICIDE ATTEMPTS | | | | |
| WEIGHT CHANGES (UNPLANNED CHANGES) | | | | | | OTHER | | | | |

*We would like you to know that we have worked with a lot of adolescents, and we respect your privacy. We hope to create an atmosphere where you feel comfortable sharing.

**TEEN INTAKE FORM (Parent/ Guardian Section)**

Parent/guardian: Please fill out pages 9-23

Adolescent Name:_____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Race/ Ethnic Origin: _____

Religious Preference: _____

## CURRENT HOUSEHOLD AND FAMILY INFORMATION

| Name | Relationship (parent, sibling, etc) | Age | Sex | Type (bio, step, etc) | Living with you? Y/N |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**(If additional space is need please list on the back of page)**

## CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which your adolescent is seeking help at this time:

_____

_____

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

_____

_____

What is most concerning right now?

_____

_____

## CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___

If yes, describe:

_____

Did your child have health problems at birth? Yes _____ No _____

If yes, describe: _____

Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

Yes ___ No ___ Not sure_____

If yes, describe:

_____

Did your child have any unusual behaviors or problems prior to age 3? Yes ___ No ___

Not sure_____ If yes, describe:

_____

Has your child experienced emotional, physical, or sexual abuse?

Yes ____ No ____ Not sure _____

If yes, describe: _____

**COUNSELING HISTORY**

Have your son or daughter previously seen a counselor? ☐ Yes ☐ No

If yes, name(s) & approximate date(s):

_____

_____

For what reason did your son or daughter go to counseling?

_____

Does your son or daughter have a previous mental health diagnosis?

_____

What did you find **most helpful** in therapy?

_____

_____

What did you find **least helpful** in therapy?

_____

_____

Has your son or daughter used psychiatric services? Yes____ No____

If yes, who did they see?_____

Was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes_____ No _____

| Name of medication | Dates taken | Was it helpful (Yes/No)? |
|---|---|---|
| | | |
| | | |
| | | |

Does your child have other medical concerns or previous hospitalizations? If yes, details:

_____

_____

**CHEMICAL USE**

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

If yes, please explain your concern:

_____

_____

**INTERNET/ELECTRONIC COMMUNICATIONS USAGE**

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

If yes, please explain your concern:

_____

**LEGAL ISSUES**

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

_____

_____

**FAMILY HISTORY**

Are you aware of any birth trauma your son or daughter experienced from age 0-5?

_____

_____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

_____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

_____

_____

**PARENT'S MARITAL STATUS** *(this question refers to the teen's biological parents' relationship)*

☐ Single ☐ Married ☐ Divorced ☐ Cohabitating ☐ Separated ☐ Widowed ☐ Other:

Length of marriage/relationship:_____

If divorced, how old was your child at time of divorce? _____

If divorced, how much time does your child spend with each parent?

Mother_____%, Father _____%

*(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)*

**Biological Father's Name:** _____ **Birth Date:**_____ **Age:** _____

Ethnic Origin: _____

Highest degree of education completed: _____

Occupation: _____ Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Current Marital Status: Single ____ Married ____ Divorced ____ Separated_____ Widowed_____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

**Biological Mother's Name:** _____ **Birth Date:**_____ **Age:** _____

Ethnic Origin: _____

Highest degree of education completed: _____

Occupation: _____ Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Current Marital Status: Single ____ Married ____ Divorced ____ Separated_____ Widowed_____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

**FAMILY CONCERNS** *(Please check any concern for you 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 | | Infidelity |
| | Death of a family member | | Divorce/ separation |
| | Financial problems | | Issues regarding remarriage |
| | Abuse/ neglect | | Birth of a sibling |
| | Feeling unsafe | | Birth of a child |
| | Job change or job dissatisfaction | | Other: |

Other concerns not listed: _____

**YOUR ADOLESCENT'S STRENGTHS**

What positive qualities would you say your son or daughter has?

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking), or beliefs (e.g. religion) in your son or daughter's life? (Please describe)

_____

_____

## INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER

| SYMPTOM | NONE | MILD | MOD | SEVERE | SYMPTOM | NONE | MILD | MOD | SEVERE |
|---|---|---|---|---|---|---|---|---|---|
| SADNESS | | | | | APPETITE CHANGES | | | | |
| CRYING | | | | | WEIGHT CHANGES (UNPLANNED CHANGES) | | | | |
| SLEEP DISTRUBANCES | | | | | PARANOID THOUGHTS | | | | |
| DISSOCIATION | | | | | POOR CONCENTRATION | | | | |
| HYPERACTIVITY | | | | | INDECISIVENESS | | | | |
| BINGING/PURGING | | | | | LOW ENERGY | | | | |
| DECREASED SEX DRIVE | | | | | EXCESSIVE WORRRY | | | | |
| UNRESOLVED GUILT | | | | | LOW SELF WORTH | | | | |
| IRRITABILITY | | | | | ANGER ISSUES | | | | |
| NAUSEA/ INDIGESTION | | | | | SPIRITUAL CONCERNS | | | | |
| SOCIAL ANXIETY | | | | | HALLUCINATIONS | | | | |
| SELF MUTALATION | | | | | RACING THOUGHTS | | | | |
| CUTTING | | | | | RESTLESSNESS | | | | |
| IMPULSIVITY | | | | | DRUG USE | | | | |
| NIGHTMARES | | | | | ALCOHOL USE | | | | |
| HOPELESSNESS | | | | | DECREASED CREATIVITY | | | | |
| ELEVATED MOOD | | | | | EASILY DISTRACTED | | | | |
| MOOD SWINGS | | | | | TRAUMA FLASHBACKS | | | | |
| DISORGANIZED | | | | | WORK ISSUES | | | | |
| ANOREXIA | | | | | PROBLEMS AT HOME | | | | |
| SOCIAL ISOLATION | | | | | PANIC ATTACKS | | | | |
| PHOBIAS | | | | | FEELING ANXIOUS | | | | |
| OBSESSIVE THOUGHTS | | | | | FEELING PANICKY | | | | |
| GRIEF | | | | | SUICIDAL THOUGHTS | | | | |
| HEADACHES | | | | | PAST SUICIDE ATTEMPTS | | | | |
| LONELINESS | | | | | OTHER | | | | |

Is there anything else you would like to share?

## Informed Consent

Everyone participating in therapy is entitled to ***confidentiality*** with certain exceptions. These include situations where a client presents a danger to him/herself, an expressed danger to others, or where the therapist suspects that abuse of a child under the age of 18, an elder over 65 or a dependent adult is occurring or has occurred. Your child has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

Therapy involves both benefits and risks. The style of therapy I use is a combination of counseling, guidance, coaching, advice giving, education, and homework. We will establish goals for your treatment so that your needs and objectives are met. There are no guarantees with any form of therapy. You may feel worse before you feel better and/or your relationships may suffer as you begin to feel better. The possible risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. Should you notice any negative effects, please tell us immediately.

**Professional Conduct and Ethics:** I agree to abide by the Ethical Standards of the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. These standards are accessible on the Georgia Board's website http://sos.georgia.gov

**Cancellations and Missed Appointments:** Therapy appointments are made in advance and this time is held for you. If you are unable to attend a scheduled appointment, please give as much notice as possible. I require ***24 hours notice to cancel or reschedule*** an appointment. Without 24 hours notice, or if you are a "no show" for your appointment, you will be charged for your missed appointment.

**Therapeutic Touch:** On occasion, and only with your permission, we will use therapeutic touch during trauma therapy sessions. The touch may involve you remaining sitting on your chair or couch and receiving a supportive hand to hold, or the grounding touch of a hand on your shoulder, neck, or back. It is understood that therapeutic touch and the client-therapist relationship is always non-sexual and only happens if you as the client want or need it.

**Insurance:** We are what is referred to as an "Out of Network Provider." We do not bill your insurance company and payment is due at each session. However, we will provide a "Super-bill" if

you are eligible for reimbursement from your insurance company. Services may be covered in full or in part by your health insurance company or employee benefit plan.

**Telephone, text, and email policy:** Generally, we ask that clients reserve discussing problems that arise between sessions for the next scheduled appointment time. We encourage you to use resources you have and to reach out to your support system. Unless there is an emergency, our schedules do not permit us to talk on the phone, respond to lengthy texts or answer lengthy emails in between sessions. If you feel the need to text or email information beyond the routine scheduling of appointments, we will wait to discuss the content in our next scheduled session. If telephone calls are necessary for a client emergency, please schedule a time for a telephone consultation, which will be charged at our regular rates (in 15-minute segments). I check voicemail and email Monday through Friday 9 AM-5 PM. To ***contact me between sessions***, please call and leave a message on my confidential voicemail. Videoconference technology is reserved for therapy sessions only. I will give you my business card with my contact phone number. Your call will be returned within the next business day. If you are having a life-threatening emergency, **please call 911 immediately**.

**Divorce and/or Custody Cases:** We ask all our clients waive the right to subpoena us to court. This policy is set in order that we can preserve the efficacy and integrity of our therapeutic progress and relationship with you and/or your child(ren). It is our experience that our appearance in court often damages our therapist-client relationship and it is our ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of our clients. By signing this agreement, you are waiving right to have us subpoenaed and agreeing in fact not to have our records or us subpoenaed. We will be happy to provide a referral to another therapist who will be willing to appear in court if needed as an alternative if you would prefer.

In the case we are subpoenaed to appear in court even with this waiver – whether we testify or not – we charge double our standard fee for Court Related work ($400/hour). Any of our time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed at $400 per hour. If we are requested for a half-day appearance, we require a 5-hour retainer of $2000. For a full-day appearance, we require a 10-hour retainer of $4000. All retainers must be paid in advance. As a general policy, we cannot be available "on-call," as being called to come to court at the last minute in that fashion is too disruptive to our practice, and not fair to our clients that otherwise would be scheduled that day, taking off time from work and/or taking their children out of school to come to our office.

**Physical Examination:** We strongly recommend that each client obtain a thorough physical exam prior to commencing therapy. This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

My fee is $200 for a 50-minute individual session. Payment is due at the end of each session.

**Having read and understood the above, I agree to these conditions of our work together.**

Signature of Client _____ Date _____

Signature of Parent _____ Date _____

Signature of Therapist _____ Date _____

# INFORMED CONSENT FOR TELEMENTAL HEALTH

*What is Telemental Healthcare?*
Telemental healthcare includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making through the use of internet-based videoconferencing. Telehealth psychotherapy may include psychological health care delivery, consultation, coaching, and/or counseling. Telehealth psychotherapy will occur primarily through interactive audio, video, and telephone communications.

*Risks of Telemental Health*
1. Technological failure, such as unclear video, loss of sound, poor connection, or loss of connection.
2. Nonverbal cues are less readily available to both the therapist and the client.

*Benefits of Telemental Health*
1. Less limitations by geographical location.
2. Reduction of travel to a physical office, which includes decrease in travel time.
3. Participation in therapy from your own home or the environment of your choosing.

Telemental health delivery by Karen Hebert, LMFT, LPC may occur only with current residents of Georgia. The current laws that protect privacy and confidentiality also apply to telemental health. Any exceptions to confidentiality are described in the Informed Consent document.
All existing laws regarding client access to mental health information and copies of mental health records apply.

No permanent video or voice recordings are kept from telemental health sessions. Clients may not record or store videoconference sessions or face-to-face sessions without written permission.

*Expectations of client during each session*
1. Minimum bandwidth connection of 384 kb or higher.
2. Minimum resolution of 640x360 at 30 frames per second.
3. Operational web camera (HD 1080p is recommended).
4. Proper lighting and seating to ensure a clear image of each party's face.
5. Dress and environment appropriate to an in-office visit.
6. Only agreed upon participants will be present. The presence of any individuals unapproved by both parties and not part of the treatment plan will be cause for termination of the session.
7. Valid ID must be presented by the client during the initial consultation. In addition, a copy must be provided by the client for the medical file.
8. The client must disclose the physical address of their location at the start of the session. Unknown locations will be cause for termination of the session.
9. The client shall also provide a phone number where they can be reached in the event of service disruption.

Telemental health may not be the most effective form of treatment for certain individuals or presenting problems. If it is believed the client would benefit from another form of service (e.g. face-to-face sessions) or another provider, an appropriate referral will be made. If it would be beneficial for occasional face-to-face sessions with Karen Hebert, LMFT, LPC, this will be discussed as part of the treatment plan and the client has the right to refuse such a recommendation. This may result in a referral to another provider as well. All referrals will adhere to the Georgia Composite Board Code of Ethics for Licensed Professional Counselors and the American Association for Marriage and Family Therapy Code of Ethics.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
I have read and understand the information provided above. I have the right to discuss any and all of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

Other risks include but are not limited to:
Although all text messages, voice mail and email are kept confidential, choosing this method may lead to your information not being protected. If you choose to communicate with your therapist in this manner, you must understand the risk and consent to using the following email, cell, and text below.
I consent to using email communication using the following email(s):

_____

I consent to using text messages using the following cell number(s):

_____

I consent to my therapist leaving me voicemail messages on the above cell number(s):

YES _____ NO_____

*Zoom Video*
I consent to using Zoom for therapy. Yes _____ No_____

*Emergency protocol*
In the event of a medical or mental crisis event, Karen Hebert, LMFT, LPC, will contact the patient's emergency contact. If she cannot get ahold of that person, Karen will contact the client's local emergency services. The information provided will include the nature of the crisis and immediate needs of the client.

*Response to technical difficulties*
Should technical difficulties cause session disruption, Karen Hebert, LMFT, LPC will contact the client via preferred telephone contact. If the technical difficulties can be resolved quickly, the session will resume and the client will not experience a shortened session length. If the technical issues cannot be resolved in a timely manner, the session will be rescheduled for a time when functionality is restored. The client will be contacted by email or phone to develop a plan for continuation of the session.

*Consent to Treatment*
I, voluntarily, agree to receive Telemental Healthcare assessment, care, treatment, or services and authorize Karen Hebert, LMFT, LPC provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Karen Hebert at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Signature of Client _____ Date _____

Signature of Parent _____ Date _____

## HIPPA NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I hereby acknowledge that I received a copy of Sweetwater Practice's "HIPAA Notice of Privacy Practices" written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand I can obtain this practice's current Notice on request.

Signature of Client _____ Date _____

Signature of Parent _____ Date _____

## Limits of Confidentiality

Information discussed in the therapy setting is held confidential and not shared without written permission except under the following conditions:

1. If the client threatens suicide.*
2. If the client threatens to harm another person.*
3. If I have reason to suspect that a minor is being abused: including, but not limited to physical abuse, sexual abuse and unjustifiable cruelty or unreasonable punishment.*
4. If I have reason to suspect that an elderly person over 65 years of age or a dependent adult is being abused.*
5. If I am ordered by the courts to break confidentiality to comply with legal requirements.
6. If I consult with other marriage & family therapists, social workers or psychologists in order to provide you with the best care and service.
7. If I have a written release from you, authorizing me to speak with a party you designate such as an insurance company representative, doctor, other healthcare provider, school or family member.

* State law mandates that mental health professionals need to consult with social services to report these situations to the appropriate agency designated to receive such report.

**Having read and understood the above, I agree to these limits of confidentiality.**

Signature of Client _____ Date _____

Signature of Parent _____ Date _____

Signature of Therapist _____ Date _____

# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

| **Credit Card Information** |
|---|
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX<br>☐ Other _____ |
| Cardholder Name (as shown on card): _____ |
| Card Number: _____ Security Code: _____ |
| Expiration Date (mm/yy): _____ |
| Cardholder ZIP Code (from credit card billing address): _____ |

I, _____, authorize Sweetwater Practice, LLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Credit Card Holder Signature Date

## Cancellations, Missed Appointments, and Collections Policy

Your appointment time has been reserved exclusively for you. If you must cancel your appointment, please do so as far ahead of time as possible. All cancellations must be made no less than 24 hours in advance of your scheduled appointment time. If the appointment is scheduled for Monday, it must be cancelled the previous Friday. This will allow adequate time to reschedule another client into that time slot. **If you do not cancel within the aforementioned 24 hour period, you will be responsible for payment of the full fee for the missed appointment.** Please be aware I do enforce this policy.

All unpaid balances **plus an additional 30% surcharge** will be sent to a collection agency for recovery after 60 days. Balances not paid to the collection agency 60 days after their initial billing will then be sent to the Credit Bureau and will appear on your credit report. **By signing this form, you are stating that you understand all of the policies listed and are agreeing to the release of your name to my collection agency if your bill is unpaid after 60 days.**

Signature of Client _____ Date _____

Signature of Parent _____ Date _____

Signature of Therapist _____ Date _____

## THE AMEN CLINIC QUESTIONNAIRE

For each item, please describe your experience of your teen today or in the past two weeks using the following scale. (0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently)

____ 1. Frequent feelings of nervousness or anxiety
____ 2. Panic attacks
____ 3. Avoidance of places due to fear of having an anxiety attack
____ 4. Symptoms of heightened muscle tension (sore muscles, headaches)
____ 5. Periods of heart pounding, nausea, or dizziness (not w/ exercise)
____ 6. Tendency to predict the worst
____ 7. Multiple, persistent fears or phobias (dying, doing something crazy)
____ 8. Conflict Avoidance
____ 9. Excessive fear of being judged or scrutinized by others
____ 10. Easily startled or tendency to freeze in intense situations
____ 11. Seemingly shy, timid, and easily embarrassed
____ 12. Bites fingernails or picks skin
**____ Total number of questions with a score of 3 or 4 for questions 1- 12**

____ 13. Persistent sad or empty mood
____ 14. Loss of interest or pleasure from activities that are normally fun
____ 15. Restlessness, irritability, or excessive crying
____ 16. Feelings of guilt, worthlessness, helplessness, hopelessness
____ 17. Sleeping too much or too little, or early morning waking
____ 18. Appetite changes/ weight loss or weight gain through overeating
____ 19. Decreased energy, fatigue, feeling "slowed down"
____ 20. Thoughts of death or suicide, or suicide attempts
____ 21. Difficulty concentrating, remembering, making decisions
____ 22. Physical symptoms; headaches, chronic pain, digestive problems
____ 23. Persistent negativity or low self esteem
____ 24. Persistent feeling of dissatisfaction or boredom
**____ Total number of questions with a score of 3 or 4 for questions 13-24**

____ 25. Excessive or senseless worrying
____ 26. Upset when things are out of place or don't go according to plan
____ 27. Tendency to be oppositional or argumentative
____ 28. Tendency to have repetitive negative or anxious thoughts
____ 29. Tendency toward compulsive behaviors
____ 30. Intense dislike of change
____ 31. Tendency to hold grudges
____ 32. Difficulty seeing options in situations
____ 33. Tendency to hold on to own opinion and not listen to others
____ 34. Needing to have things done a certain way or you become upset
____ 35. Others complain you worry too much
____ 36. Tendency to say no without first thinking about the question
**____ Total number of questions with a score of 3 or 4 for questions 25-36**

0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently

____ 37. Periods of abnormally happy, depressed or anxious mood
____ 38. Periods of decreased need for sleep, energetic on much less sleep
____ 39. Periods of grandiose thoughts and ideas (feeling very powerful)
____ 40. Periods of increased talking or pressured speech
____ 41. Periods of too many thoughts racing through your mind
____ 42. Periods of increased energy level
____ 43. Periods of poor judgment that leads to risk-taking behaviors
____ 44. Periods of inappropriate social behavior
____ 45. Periods of irritability or aggression
____ 46. Periods of delusional or psychotic thinking
**____ Total number of questions with a score of 3 or 4 for questions 37 – 46**

____ 47. Short fuse or periods of extreme irritability
____ 48. Periods of rage without being provoked
____ 49. Often misinterprets comments as negative when they are not
____ 50. Periods of spaciness or confusion
____ 51. Periods of panic or fear for no specific reason
____ 52. Visual or auditory changes (seeing shadows or hearing sounds)
____ 53. Frequent periods of déjà vu (feeling you've been somewhere before)
____ 54. Sensitivity or mild paranoia
____ 55. Headaches or abdominal pain or uncertain origin
____ 56. History of head injury or family history of violence/ explosiveness
____ 57. Dark thoughts, may be homicidal or suicidal
____ 58. Periods of forgetfulness or memory problems
**____ Total number of questions with a score of 3 or 4 for questions 47- 58**

____ 59. Trouble staying focused
____ 60. Spaciness or feeling like you're in a fog
____ 61. Overwhelmed by tasks of daily living
____ 62. Feels tired, sluggish, or slow moving
____ 63. Procrastination, failure to finish things
____ 64. Chronic boredom
____ 65. Loses things
____ 66. Easily distracted
____ 67. Forgetful
____ 68. Poor planning skills
____ 69. Difficulty expressing feelings
____ 70. Difficulty expressing empathy for others
**____ Total number of questions with a score of 3 or 4 for questions 59-70**