CENTRAL VIRGINIA COUNSELING PLLC
808 Wiggington Rd. Suite D
Lynchburg, Va. 24503
Phone: 434-616-4980

CHILD/ADOLESCENT INTAKE FORM

Date: _____ Referred by: _____

Name:
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ SSN: _____ - _____ - _____ Age: _____
Gender: □ Male □ Female

Local Address:
_____
(Street and Number) (City) (State) (Zip)

Home Phone: _____
May we leave a message? □ Yes □ No
Cell/Other Phone: _____
May we leave a message? □ Yes □ No
In case of an emergency please notify:_____
Emergency Contact Phone # _____

PARENT INFORMATION:
Mother's Name: _____ Age: _____
Occupation _____
Marital Status: _____

Father's Name: _____ Age: _____
Occupation _____ _____
Marital Status: _____

OTHER CHILDREN: Please list names and ages:
_____ _____
_____ _____

INSURANCE INFORMATION:
_____ _____
Insurance Provider Policyholder's Name/Date of Birth
_____ _____
Policy Number Group Number

CHILD/ADOLESCENT INTAKE FORM-THIS PAGE TO BE COMPLETED BY MINOR CHILD-Page 2

ACADEMIC/SCHOOL PERFORMANCE:
What type of student are you?:
□ Excellent □ Above Average □ Average □Poor
I am not passing some of my classes □ Yes □ No
How do you feel about school?

_____
_____
What is your favorite subject in school? Least favorite?

_____

What types of extracurricular activities are you involved in or outside of school?

_____
_____
How well do you get along with your teacher (s)?

_____
_____
How well do you get along with your peers?

_____
_____
How would you describe you current home life?

_____
_____
How do you feel about the rules in your family?

_____
_____
Who do you spend most of your leisure time with? What do you like to do for fun?

_____
_____
EMOTIONAL STATUS:
Describe yourself: (you may check more than one)
□ Happy □ So So □ Unhappy □ Sad □ Sometimes depressed □ Frequently depressed
□ Angry □ Sensitive to other's opinions □ Don't care
How do you feel about yourself?
□ Love myself □ Like myself □ Dislike myself □ Hate myself
Describe how you think others feel about you:
□ Most people like me □ A few people like me □ I'm generally disliked □ I'm fun to be with □ I'm usually a boring person
Have you had suicidal thoughts recently?
□ Frequently □ Sometimes □ Rarely □ Never
Have you had suicidal thoughts in the past?
□ Frequently □ Sometimes □ Rarely □ Never
Client Signature: _____ Date: _____

CHILD/ADOLESCENT INTAKE FORM-Page 3

Is your child currently receiving psychiatric or psychotherapy services elsewhere?
□ Yes □ No If yes, please state provider name and dates of service:
_____
_____
_____

Has your child had previous counseling?□No □Yes If yes, please give provider name and dates of
service:_____
_____
_____
Is your child currently taking prescribed medication?
□Yes □No If Yes, please list:
_____
_____
If no, has your child previously received prescribed psychiatric medication?
□Yes □No If Yes, please list:
_____
_____

How is your child's physical health at present? (Please check)
□Poor □Unsatisfactory □Satisfactory □Good □Very good
Please list any concerns:
_____
_____
_____

Is your child having any problems with sleep habits? □ No □ Yes
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams

How many times per week does your child exercise? _____
Approximately how long each time? _____

Is your child having any difficulty with appetite or eating habits? □ No □ Yes
If yes, please explain:
_____
_____

CHILD/ADOLESCENT INTAKE FORM-Page 4

Has your child ever experienced any of the following?
Depressed mood: □ No □ Yes
Extreme Mood Swings: □ No □ Yes
Rapid Speech: □ No □ Yes
Anxiety: □ No □ Yes
Panic Attacks: □ No □ Yes
Phobias: □ No □ Yes
Sleep Disturbances: □ No □ Yes
Hallucinations: □ No □ Yes
Unexplained losses of time: □ No □ Yes
Unexplained memory lapses: □ No □ Yes
Alcohol/Substance Abuse: □ No □ Yes
Frequent Body Complaints: □ No □ Yes
Trauma: □ No □ Yes
Abuse/Domestic Violence: □ No □ Yes
Repetitive Thoughts: □ No □ Yes
Repetitive Behaviors: □ No □ Yes
Homicidal Thoughts: □ No □ Yes
Suicide Attempt: □ No □ Yes
Comments:
_____
_____

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check any that apply and list family member: e.g.- sibling, parent, uncle, etc.):
Depression: □ No □ Yes _____
Bipolar Disorder: □ No □ Yes _____
Anxiety Disorders: □ No □ Yes _____
Panic Attacks: □ No □ Yes _____
Schizophrenia: □ No □ Yes _____
Substance Abuse: □ No □ Yes _____
Eating Disorders: □ No □ Yes _____
Learning Disabilities: □ No □ Yes _____
Trauma History: □ No □ Yes _____
Suicide Attempts: □ No □ Yes _____
In your own words, why are your seeking counseling for your child?
_____
_____
_____

_____ _____
Signature of Parent/Legal Guardian Date

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CLIENT SERVICE AGREEMENT

Informed Consent for Treatment:

*I, _____ for (if signing for minor)_____ do voluntarily consent to care and treatment by Central Virginia Counseling PLLC.
*I understand that psychology is not an exact science and that no guarantees are being made as the result of evaluation or treatment.
*I understand that I am an active participant in this endeavor and I share the responsibility for the treatment process, including goal setting and termination.

Benefits:

*A number of benefits are available from participating in psychotherapy. The benefits you obtain from therapy depend on how well you use the process and put into practice what you learn. Some of the benefits from therapy include: attaining a better understanding of yourself and your personal goals, developing skills for improving your relationships, overcoming specific problem areas, and finding resolution to the concerns which led you to seek therapy. However, there are no guarantees about what therapy will do for you. Some people find that participating in psychotherapy results in changes that were not anticipated or intended at the outset.

Risks:

*There are certain risks associated with the counseling process that should be understood. For example, in counseling, there is a risk that clients will, for a time, experience uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other difficult feelings. Clients may recall unpleasant memories. Sometimes, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making significant changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not yield the results that you initially desired from it.

_____ _____
Parent/Guardian Initials Date

CLIENT SERVICE AGREEMENT-Page 2

Confidentiality:

*I understand that psychotherapy/therapeutic counseling, assessment, and associated services provided by licensed professionals are confidential and protected under Virginia state law. The law protects the privacy of all communications between a client and a licensed professional. In most situations, information regarding your treatment can only be released to others with your written permission. However, there are legal limits to confidentiality and times when a licensed professional is obligated to disclose pertinent information:
-If your therapist suspects that you present a danger to self or others.
-Certain major violations of the law including abuse or neglect of a minor or elderly person.
-In the case of minors, parents or legal guardians have access to their child's records, unless emancipated.
-The therapist must respond to any court subpoenas ordering the therapist to provide information to the court regarding client.

Grievance/Complaint:

*To file a formal complaint against a licensed professional, you may contact the licensing board below:
Virginia Board of Counseling
Phone: 1-800-533-1560

Emergencies:

*If you have a life threatening emergency, please call 911. After regular business hours, therapist can be contacted on after hours emergency number.

Financial:

*It is your responsibility to be aware of specific policy deductibles, co-payments, and co-insurance. It is your responsibility to remit all appropriate payments. Any estimate the office makes will be our best faith effort to determine coverage and does not guarantee payment from your insurance. The amount for which you are responsible (any deductibles, co-payments, co-insurance, or non-covered services) will be required at the time of the service.
*If this practice is not contracted with your specific insurance plan, even if you have out of network benefits, all charges will be due at the time of service.

_____ _____
Parent/Guardian Initials Date

CLIENT SERVICE AGREEMENT-Page 3

*Your insurance policy is a contract solely between you and your insurance company. If you fail to notify us of an insurance change, you will be fully responsible for any amount not paid by your insurance company. Keep in mind that most insurance companies limit sessions and require a medical diagnosis in order to reimburse expenses. Such a diagnosis will often end up in your permanent insurance record. We can discuss any questions or concerns that you have about insurance reimbursement.
*For service rendered to minor clients, the accompanying parent will be responsible for payment.
*24 hour notice of cancellation is required to avoid being charged a late cancellation fee. Any failed appointments or late cancellations will be charged in full. Your insurance provider will not reimburse for missed or failed appointments. Two consecutive failed appointments may result in a referral to another therapist. The fee for any check returned for non-payment is $50.
*In unusual circumstances, you may become involved in litigation wherein you require a therapist's participation. You will be expected to pay for such professional time even if the therapist is compelled to testify by another party. A minimum retainer of $800 is required to cover time spent preparing for court and the initial court appearance. Thereafter, the per diem charge is $750 for subsequent appearances. All charges for preparation and court appearances are payable in advance.
*I understand that I am responsible for charges incurred by persons/agencies who are consulted as part of my treatment.

Termination:
*Counseling is voluntary. Both you and your therapist reserve the right to transfer/ terminate services at any time, for any reason.

Insurance Authorization and Assignment:
I hereby authorize Central Virginia Counseling PLLC to furnish information to insurance carriers concerning my treatment and I hereby assign to the provider all payments for professional services rendered to myself or to my dependents. I have read the above Client Service Agreement and understand that by signing this form I will be held financially responsible for this account. I hereby grant permission for Central Virginia Counseling PLLC to provide therapeutic counseling services to my child.

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

_____
Date
I hereby state that I have managing conservatorship for _____(child's name) and have the legal right to grant consent for mental health treatment. I give my permission for him/her to receive counseling services and will provide court documentation regarding conservatorship at the request of the counselor. _____
(Parent/Guardian Initials)