Nightingale Behavioral and Counseling Services
Melissa Lara LeMay, LMHC, BCBA, PCIT Therapist

This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

Adolescents and Teens please fill out pages 1-3, parent/guardian please fill out pages 4-7.

ADOLESCENT/TEEN INTAKE FORM (ages 12-17)

CLIENT INFORMATION

Name:_____
Date of Birth: _____ Age: _____ ❒ Male ❒ Female
Physical Address: _____
Mailing Address: _____
Phone (Cell): _____ Messages okay?_____
Phone (Home): _____ Messages okay?_____
School: _____ Grade: _____
Race/Ethnic Origin: _____
Religious Preference: _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?

_____

_____

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

_____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking counseling?

_____

_____

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

_____

_____

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? _____
_____

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? Y/N _____
If so, where did you go?_____
____Inpatient ____Outpatient

ADOLESCENTS/TEENS (*please answer the following with* Y/N)

Have you ever used more than 1 chemical at the same time to get high? _____
Do you avoid family activities so you can use? _____
Do you have a group of friends who also use? _____
Do you use to improve your emotions such as when you feel sad or depressed?? _____

LEGAL ISSUES

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

FAMILY HISTORY

Are your parents married or divorced? _____
Do you think their relationship is good? (Y/N/Unsure)_____
If your parents are divorced, whom do you primarily live with? _____
How often do you see each parent? Mom_____% Dad _____%.
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 family concerns that your family is currently experiencing*)

Fighting	Disagreeing about relatives
Feeling distant	Disagreeing about friends
Loss of fun	Alcohol or Drug use
Lack of honesty	Trauma
Medical Concerns	Infidelity (couple)
Education problems	Divorce/separation
Financial problems	Issues regarding remarriage
Death of a family member	Birth of a child
Inadequate health insurance	Job change or job dissatisfaction
Inadequate housing/feeling unsafe	Other

Other concerns not listed above _____

PEER RELATIONS

How do you consider yourself socially: ___outgoing ____shy ____depends on the situation. Are you happy with the amount of friends you have? (Y/N)_____
Have you ever been bullied? (Y/N) _____

Are your parents happy with your friends? (Y/N)_____
Are involved in any organized social activities (e.g. sports, scouts, music)?
_____

SCHOOL HISTORY

Do you like school? (Y/N)_____
Do you attend regularly? (Y/N)_____
What are your current grades? _____
Do you feel you are doing the best you can at school? (Y/N) _____

Is there anything else you would like me to know: _____
_____
_____

Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT/TEEN INTAKE FORM (PARENT SECTION)

Adolescent's/Teen's Name: _____Date of Birth: _____
Mother's/Guardian's Name: _____ Phone Contact:_____
Mother's/Guardian's Physical Address: _____
Mother's/Guardian's Mailing Address: _____
Father's/Guardian's Name: _____ Phone Contact:_____
Father's/Guardian's Physical Address: _____
Father's/Guardian's Mailing Address: _____

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 For Your Adolescent or Teen

Briefly describe the problem for which your adolescent is seeking to have counseling for?
_____
_____
What would you like to see happen as a result of counseling?
_____
_____
What is most concerning right now?
_____
_____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor?❒Yes❒No
If Yes, where: _____

Approximate Dates of Counseling: _____
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?

_____

If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes_____ No _____
Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe: _____

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:

_____

_____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____
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? (Y/N) _____
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

(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.)

Father's Name: _____Birth Date:_____ Age: _____
Ethnic Origin: _____
Total years of education completed: _____ Occupation: _____
Place of Employment: _____
Military experience? Y/N _____ Combat experience? Y/N _____
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____
Mother's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____
Total years of education completed: _____ Occupation: _____
Place of Employment: _____
Military experience? Y/N _____ Combat experience? Y/N _____
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

PARENT'S MARITAL STATUS

❒Single❒Married (legally)❒Divorced❒Cohabitating❒Divorce in process❒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 _____%

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

Fighting	Disagreeing about relatives
Feeling distant	Disagreeing about friends
Loss of fun	Alcohol or Drug use
Lack of honesty	Trauma
Medical Concerns	Infidelity (couple)
Education problems	Divorce/separation
Financial problems	Issues regarding remarriage
Death of a family member	Birth of a child
Inadequate health insurance	Job change or job dissatisfaction
Inadequate housing/feeling unsafe	Other

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

_____

_____

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

_____

_____

YOUR ADOLESCENT'S/TEEN'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

_____

_____

What personal 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)

_____

_____

Is there anything else you would like me to know: _____

_____

_____

AGREEMENT FOR SERVICE / INFORMED CONSENT

This document contains important information about my professional services and business policies, including limits of confidentiality. Please read it carefully. When you sign this document, it will represent an agreement between us.

Risks and Benefits of Therapy. Participating in therapy can result in a number of benefits to you, including a deeper understanding of yourself and your personal goals, improved relationships with others, and resolution of the specific concerns that are your motivation for beginning therapy. However, therapy can have risks as well as benefits. While the primary goal of therapy may be to improve your well-being, it can also result in considerable discomfort. You may experience uncomfortable feelings such as sadness, guilt, anger, shame, frustration, loneliness, and helplessness. Should you have any concerns regarding your progress in therapy, it is important to let me know.

Records and Record Keeping. The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead.

Confidentiality. The information disclosed by you in therapy is generally confidential and will not be released to others without your written consent. However, there are a few exceptions. Exceptions to confidentiality, include:

- If there is reason to believe a child, elderly person, or dependent adult is or has been abused.
- If you threaten to commit serious bodily harm to yourself or another person.
- If I am presented with a subpoena or court order that has been signed by a judge.

In any of the above circumstances, I will only reveal the minimum information that is necessary, and I will do my best to inform you of the information being disclosed and to whom it will be provided before I do so.

Minors and Confidentiality. If you are a minor, under the age of 18, your parents or guardians may be legally entitled to some information about your therapy. I will discuss with you and your parents/guardians what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Fee and Fee Arrangements. A standard session is 50 minutes. All fees are due at the time of service. Please ask if you wish to discuss a written agreement that specifies an alternative payment procedure. If for some reason you find that you are unable to continue paying for your therapy, please let me know. I would be happy to help you to consider any options that may be available to you at that time.

Insurance. I accept numerous insurances. Please provide me your insurance information in order for me to verify benefits and coverage. If your insurance plan provides reimbursement for out-of-network providers, I can provide you with a statement, which you can submit to your insurance company to receive some insurance reimbursement, depending upon your benefits. You should be aware that insurance companies require

that some clinical information is shared in order to reimburse for services. All insurance companies require a clinical diagnosis. Some may require additional information such as treatment plans or treatment summaries. In these instances I will disclose the minimum amount of information required for the requested purpose. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage, and that you are responsible for any and all fees not reimbursed by your insurance company. Please let me know if you have any questions or concerns.

Cancellation Policy. Standard policy for most therapists, myself included, is a 24-hour cancellation policy. If you do not show up for your scheduled therapy appointment, and have not notified me at least 24- hours in advance, payment will be required for the full cost of the session. A total of two missed appointments without prior notification may lead to ending the therapy relationship.

Therapist Availability and Emergencies. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee your call will be returned immediately. I am unable to provide 24-hour crisis service. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, please call 911, (800) TLC-TEEN (800-852-8336) or text TEEN to 839863, or call the National Suicide Prevention Lifeline at 1-800-273-8255, or go to the nearest local emergency room.

Social Media and Telecommunication. Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Electronic Communication. I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. Threats to confidentiality include, but are not limited to: 1) the transmission may be intercepted; 2) the transmission may be sent to the wrong recipient; and 3) the e-mail or text message may be accessed by an unauthorized person. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Termination of Therapy. Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment, after appropriate discussion with you, if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. You also have the right to terminate therapy at your discretion. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for four consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

CONSENT TO TREATMENT

I, _____, have read *Agreement for Services/Informed Consent*. In signing below, I consent to treatment and agree to abide by its terms during the course of therapy.

Patient Name (please print)

_____

Signature of Patient (or authorized representative) Date

_____

Parental Consent to Treat a Minor

I, _____ (Name of Parent or guardian of child), give my permission for my child, _____ (Full Name of Minor), _____ (Birth Date of Minor), to be treated by Melissa Lara LeMay, LMHC, BCBA in psychotherapy. I also understand that in order for therapy to be successful with any individual, their confidentiality needs to be respected, even in the case of a minor child, with exceptions of if the minor is a danger to him/herself or to others.

I understand that this permission to treat with respect for my child's confidentiality is given with my full consent. This consent will be valid throughout the duration of therapy, or until the following date: _____ (Date consent expires).

_____

Parent or guardian's signature Relationship to minor Today's date

_____

Name and Address of Parent or guardian (Street, City, State and Zip)

_____

Other parent or guardian's signature Relationship to minor Today's date

_____

Name and Address of other parent or guardian (Street, City, State and Zip)

_____

Address of minor (Street, City, State and Zip)