INSTRUCTIONS FOR ENCLOSED FORMS

CHILD AND FAMILY

Generally, for individual counseling with a child or youth or for family therapy, a parent will be bringing their child or youth to counseling. In this case, the parent(s) should complete forms 1 through 5 below. If only one parent is attending, then only that parent need complete the forms (with the exception that both parents may still need to sign the Parental Consent for Treatment form, if the parents are separated or divorced and are bound by a custody agreement or court order that requires it). If both parents are attending, they should both complete the forms.

1. **"Contact Information"** form. This form provides us with your contact information and allows you to specify how you would like to be contacted in the future by Cobb & Associates.

2. **"Informed Consent and Authorization for Services"** form. This form summarizes important information about confidentiality, fees, cancellation policies, and other practices and policies of Cobb & Associates. Please review it, initial where necessary, and sign page 5.

3. **"Parental Consent for Treatment"**. Consent for providing treatment services to a minor is required by the parent(s) or guardian(s) of the minor.

4. **"Intake Questionnaire".** This questionnaire aids assessment and treatment planning by giving your clinician a quick overview of your background and current situation at a glance. Each parent attending counseling should complete the Adult form. An older youth or "mature minor" can complete this form as well and skip the form below.

Plus:

5. **"Intake Questionnaire – Child".** One of the parents should complete the Child form for each child that is the focus of treatment.

Please bring these forms with you to your initial session. All information you provide in this form will be kept as part of your confidential file. Feel free to discuss any questions with your therapist before signing.

CONTACT INFORMATION

Printed Name: _____ Birthdate: _____

Mailing Address: _____
Street Address City Province Postal Code

This must be an address to which we can send correspondence, as needed. The name "Cobb & Associates" will not be displayed on the envelope.

Home Phone: (_____) _____ May a message be left at this number? Yes □ No □

Cell Phone: (_____) _____ May a message be left at this number? Yes □ No □

Work Phone: (_____) _____ May a message be left at this number? Yes □ No □
(Optional)

Email Address: _____
(Optional)

□ *I understand that writing in my email address (above) is giving explicit consent to Cobb & Associates to use that email address to correspond with me* in all matters directly related to the provision of services (includes invoicing; appointment bookings, confirmations and reminders; follow-up on services, etc.).

Would You Like to be on Our Email Newsletter List? (Please Check One of the Statements below):
Our monthly newsletter contains articles on building strong relationships and mental and emotional wellness, links to online resources and book recommendations that you can use to improve your situation, as well as notices of upcoming workshops or new services.

□ Yes, I would like to receive monthly email newsletters from Cobb & Associates (using the email address above)

□ No, I do not wish to receive monthly newsletters

Help us Better Reach Others Who Also Need Help
Please let us know who recommended us to you or how you otherwise learned about Cobb & Associates Inc.

□ I am a Boom Group member
□ My Insurance Provider
□ My Employer (*Circle one:* Supervisor/Manager • Human Resources • Psych Services • Occupational Health)
□ My Physician or Psychiatrist
□ Another Psychologist or Therapist
□ My (*Circle one):* Chiropractor • Acupuncturist • Naturopath • Massage Therapist • Or Other Professional
□ My Lawyer
□ My Priest, Pastor, Bishop or other Church Leader
□ A Family Member, Friend or Personal Acquaintance
□ A workshop or seminar that I attended
□ After being first referred by one of the above, I also searched for Cobb & Associates on the Internet
□ I found you primarily by doing a search on the internet: I clicked on a Google Advertisement at the top of the page
□ I found you primarily by doing a search on the internet: I clicked on one of the organic search results that came up
□ I found you primarily by doing a search on the internet: I found you in the Yellow Pages online
□ A Referral Service *(Circle one:* Psychologists' Association of Alberta • AAMFT Therapist Locator • Other)
□ My Professional Association (i.e. Law Society, APEGA, AREA, CPA Alberta, CAJ, etc.)
□ I am a returning client
□ My spouse/partner or other family member was referred to you or found you
□ Other _____

_____ _____
Signature Date

INFORMED CONSENT

AND AUTHORIZATION FOR SERVICES

Welcome to Cobb & Associates Inc..

This form provides information about the practice and privacy policies of Cobb & Associates Inc. This information is intended to help you make an informed decision about accepting services from us. If you have any questions or concerns about anything on this form, please do not sign the form until you have discussed your concerns with your therapist. Within each section, a summary of the essence of that section is **highlighted in bold**.

Frequency of Sessions

Weekly or bi-weekly 50-minute sessions are most common. The frequency of sessions is based largely on your needs and situation.

How Long is Therapy?

The amount of sessions needed varies depending on the nature of each person's concerns, the complexity of the issues involved, the strength of our working relationship, and each person's commitment to work on the presenting issues. There is a direct relationship between effort applied between sessions and progress over time. Anywhere between 1 and 20 sessions is typical, though more sessions may be needed in some situations.

Fees

- **Our fees are as follows: $170 per hour with our Registered Provisional Psychologists; $180 per hour with our Registered Psychologists; and $200 per hour with Nathan Cobb, Ph.D. in MFT, RMFT, R.Psych.**
- **We prefer payment at each session rather than a regular billing process.**
- Additional time beyond the 50-minute hour is billed in 10-minute increments.
- Billable services include: face-to-face and telephone consultations (not including the initial intake or dealing with brief scheduling matters), report writing and other requested correspondence, and review of written records from other professionals.
- **Fees are payable by cash, cheque, credit card or debit**

About Privacy

- **All information you share with your therapist is private and confidential.**
- **Your information will not be released to anyone without your written permission (with some exceptions as explained below).** When information is to be released with your consent you will be consulted regarding what information is to be released.
- Your information will be kept on file in a secure and private location.
- You may review the contents of your own counseling file upon request.
- The full privacy policy for Cobb & Associates Inc. is available upon request. It can also be viewed at www.nathancobb.com/privacy-policy.html

About Privacy When Multiple Persons Are Involved in the Therapy Relationship

- Many of our clients consist of multiple family members (i.e. spouses and partners in couple's therapy, family members in family therapy**). In such cases, no information obtained from multiple family members may be released to an outside party without the prior written consent of *each person* from whom the information was obtained,** unless 1) a different agreement has been established ahead of time and documentation of such an agreement is attached to this form or 2) information about the non-consenting party can be entirely removed from the information that is shared.
- As part of the assessment phase of therapy or as otherwise indicated, your therapist may request to meet with each of you on an individual basis for one or more sessions. Unless you have collectively made a different agreement ahead of time with your therapist and documentation of such an agreement is attached to this form, please be aware that **your therapist is free to use his or her clinical judgment to decide whether, when and how to incorporate information you've shared privately with your therapist into your conjoint sessions and that disclosure of such private information by the therapist to others in therapy with you is not considered a breach of confidentiality.**

- The rationale for this policy is that it can be detrimental to the progress of your therapy or your relationship for your therapist to be in a position of having knowledge of sensitive information that the other spouse is not privy to, as it may put your therapist into a conflict-of-interest position.

Exceptions to Privacy

A client's confidential information may be released without their consent under the following conditions:

- When the purpose is **to protect individuals (including a client) who are at foreseeable and imminent risk of bodily harm or death** as a result of a client's actions.
- Under law that requires **reporting of child and elder abuse/neglect** to authorities.
- Under **subpoena from a court of law**.
- In the unlikely event of a client's account becoming 120 days past due or in the event of a dispute over a financial transaction, limited information may be shared with financial or legal agencies connected with the business of Cobb & Associates Inc. (i.e. credit card companies, collection agencies, etc.) **as necessary to resolve such disputes or to collect on unpaid accounts.** In such cases, any personal information disclosed is limited to only that which is necessary to resolve the dispute or to settle the account (i.e. dates, transaction amounts, etc.) and does not include any clinical information.
- **Exceptions that apply to personal information disclosed by minors:** Generally, but not always, the legal guardian(s) of a minor must give consent for the minor to receive treatment and has a legal right to information disclosed in therapy by the minor in order to provide nurture and protection that is in the best interest of the minor. However, if everyone agrees at the outset of therapy to terms of confidentiality between the minor and his or her guardian(s) then the therapist is bound to abide by these terms. The therapist may subsequently only disclose confidential information obtained from the minor without written consent under the terms agreed upon, or as required by law, or under the exceptions outlined above. Your therapist will discuss these exceptions further with you in session, as applicable.
- If you disclose in confidence that you have done something illegal, your therapist is *not* obligated to report this to the authorities, unless the circumstances involve child abuse, abuse against a dependent adult, or a direct threat to another person (as outlined above).

Initial Here ➔

I have carefully read the preceding sections on privacy and exceptions to privacy (or have had them explained to me) and I am satisfied that I fully understand the above stated policies on confidentiality and the limits of my confidentiality rights and I agree to proceed with counseling under these terms. _____.
Initials

Email Privacy

- Email is a quick and convenient method of communication. Many of our clients use it to correspond with us. Please be aware, however, that while every effort is made to safeguard your privacy, we cannot guarantee the confidentiality of email messages. If this is a concern for you, please do not use email to correspond with us.
- **We will only use email to communicate with you: a) in response to an email you send us, or b) as you authorize it or otherwise request it.**

Collaboration with Professional Referral Source

- If you have been referred to Cobb & Associates Inc. by another professional (i.e. mental health provider, lawyer, physician, psychiatrist, clergy, etc.), **it is customary for your therapist to contact your referral source** to acknowledge the referral at the beginning of treatment.
- **Your signature at the bottom of this form is your consent for this communication to take place.** If you do not give your consent for this communication, or if this is not applicable to you, please leave this section blank.

Enter Referral Source Name ➔

If Applicable: _____ _____
Name of Professional Referral Source Phone (If Available)

Consent to Release Information to Health Insurance Provider

- **If you will be submitting any health claims for reimbursement** to your health insurance provider for the counselling services you receive at Cobb & Associates Inc. **your health insurance provider may contact us to obtain information necessary to verify your claim**.
- The type of information they would typically request includes: 1) date of service, 2) the nature of services provided, and 3) the names of individuals who received the service.
- Our experience has shown that verification checks are not common, and that most health insurance providers will typically not request detailed diagnosis and treatment plan information, unless the insurance company was the referral source who previously contacted us on your behalf, and contracted with us to provide services to you.
- **Your signature at the bottom of this form is your consent for this communication to take place, if necessary**. If you do not give such consent, please cross off this paragraph.
- If you are not submitting any claims, check the box marked "Not applicable" below.

Enter Insurance Company Name ➔

If Applicable: _____. ☐ Not applicable
Name of Health Insurance Company

24-Hour Cancellation Policy

- **If you cannot attend an appointment, please notify our office 24 hours in advance.**
- **Please cancel by phone since email delivery is not always instantaneous or reliable.**
- The purpose of a 24-hour cancellation policy is to allow enough time for us to fill the vacant appointment slot, thereby meeting the needs of other clients who are waiting for an appointment. The therapist is essentially committing a one-hour (or longer) block of his or her time to a client's care, and only a limited number of such appointment slots can be booked in a day. A same day cancellation provides insufficient notice with which to re-book an appointment, and thus represents both lost opportunity for someone else to benefit from that time slot as well as lost revenue. **There is, therefore, a fee charged for a late cancellation or no show of 50% of the hourly rate to a minimum of $85, per one-hour appointment,** pro-rated in the event of a longer appointment slot.
- We appreciate that unforeseen events sometimes happen, but please be as respectful of our time as you can. Exceptions to this policy are rare.
- **Please be aware that third-party reimbursement providers (i.e. health insurers) typically do not reimburse for late cancellation charges or no show charges.**
- If you provide your email address or your mobile number to our scheduling system you can request an email or text message reminder notification about your appointment. Please note that these reminder notifications are a courtesy only. **Our clients are fully responsible for any appointments they have booked with Cobb & Associates Inc. even if they receive no reminder notification.**
- If you arrive late, the session will have to be shorter but will still be billed as though you had utilized the entire hour.
- If you are more than 20 minutes late, we will assume you are not attending.

Initial Here ➔

I am aware of and agree to pay the late cancellation/missed appointment fee in the event that I cancel an appointment with less than 24 hours notice. _____.
Initials

Initial Here ➔

I understand that a notification to cancel initiated after hours (i.e. after 4:30PM or on weekends or statutory holidays) for an appointment scheduled the following business day is considered a late cancellation regardless of the length of notice. _____.
Initials

Social Media

- **It is the policy of Cobb & Associates Inc. not to accept social networking invitations from past or current clients utilizing social media sites** such as Facebook, LinkedIn or other similar sites.
- This policy is in keeping with ethical guidelines that prohibit the formation of dual relationships between therapist and client. A dual relationship occurs when a therapist

and client form another type of relationship outside of the therapist-client relationship (i.e. mutual friendship, business associate, teacher, student, family member, etc.), or enter into a therapist-client relationship after another type of relationship has already been established. Such dual relationships have the potential for creating conflicts of interest, possible exploitation, and problems associated with unhealthy boundaries.

Feedback Surveys

- Cobb & Associates **utilizes a client-directed feedback system** to provide us with feedback about the effectiveness of our services. This system **consists of a number of surveys that we ask clients to complete during the process of therapy and at termination of therapy.** We use the information from this feedback system to help us determine if the counseling we are providing is effective in helping *you*, specifically, as well as gauging the effectiveness of our clinic as a whole.
- If you have provided your email address to the online scheduling system, you will receive an automatically-generated "Thank-You" email after each session containing links to these feedback surveys that are completed online.
- **We ask that you consider completing these surveys to help your therapist know what is working well in counselling, and whether anything can be adjusted in the way your therapy is conducted to help you achieve your goals.**
- These surveys are voluntary; there is no obligation to complete them.
- There are three types of surveys: 1) a brief, post-session survey that you complete after each session, 2) a more in-depth survey that you complete after every 3-4 sessions, and 3) a final termination survey to be completed after your final session.
- Up to six months from your last session, if you have previously given express consent to Cobb & Associates to use your email address (on the contact form you filled out), we will manually send you a follow-up email inviting you to complete a brief, anonymous feedback survey, with no personal identifier linking you to your responses. Again, this survey is voluntary.
- All of these surveys are confidential. Only your therapist and the director of the clinic will have access to your specific results. We do ask that you provide an identifier, known only to you and to your therapist, in each survey so that your therapist can identify you.
- Over time, the aggregated numerical results of surveys for the clinic as a whole, minus specific written comments and any other identifying information of specific individuals will be available to all clinic staff.
- **If you do not wish to receive any of the automatic, system-generated emails, we ask that you please delete your email address from the scheduling system or request that we delete your email address for you. You can do so by signing your initials below where indicated. Be aware that this will also discontinue appointment confirmations and appointment reminders by email.** Unfortunately, there is no way for us to delete the follow-up emails while retaining the ability to send you appointment confirmations and appointment reminders.
- **If you wish to participate in this feedback program, but do not wish to complete the surveys online, please inform your therapist and arrangements can be made to have you complete the surveys in hardcopy.**
- Your signature at the bottom of the form constitutes your consent to receive the system-generated surveys by email, unless you have signed your initials immediately below.

Initial Here ONLY if You Wish to Opt Out of the Follow-up Emails ➔

OPTIONAL: Please remove my email address from the Cobb & Associates Inc. scheduling system. I understand that this will not only stop the automatic follow-up / feedback survey emails from being generated, but will prevent any appointment confirmations and appointment reminders from being sent to me by email. _____.
Initials

Credentials

- Associates of Cobb & Associates Inc. have at least a master's degree in psychology,

marriage and family therapy or social work and are registered through their governing professional body (i.e. College of Alberta Psychologists, Alberta College of Social Workers) as registered psychologists, registered provisional psychologists or registered social workers.

Emergencies

- If your life or safety is in danger please phone 911 or go to the nearest emergency room. For other emergencies a useful resource is the **Calgary Distress Centre (24 hours) at (403) 266-1605.** Non-urgent concerns should be reserved for a scheduled appointment.
- You can also call our office at **(403) 255-8577**. Be aware, however, that your therapist may not always be available, particularly after hours, and may not be able to return your call immediately.

Complaints and Questions

- It is important to us that you feel you are benefiting from the services you are receiving. If at any time you are unhappy with the service you are receiving or if you are unsure about the goals or purposes of treatment, please express your concerns to your therapist directly. We will do our best to resolve your concerns and answer your questions.
- If you would prefer, your therapist will also assist you with a referral to another professional.
- If we can improve the service you are receiving in any way, please let us know.

YOUR SIGNATURE

I have read this letter in full, and I have been informed of the procedures and conditions as outlined in this letter. I have had an opportunity to discuss these procedures and conditions with my therapist and I am satisfied that my questions have been answered to the extent possible. I accept the help offered with full knowledge and understanding of the relevant procedures and conditions.

_____	_____	_____
Name	Signature	Date

PARENTAL CONSENT FOR TREATMENT

I/we, _____ and _____,
(Name of custodial parent/ guardian) (Name of other custodial parent/ guardian, if necessary – see below)

consent to _____, providing counseling services to:
(Name of therapist)

_____ _____
(Name of minor/dependent adult) (Date of birth)

_____ _____
(Name of minor/dependent adult) (Date of birth)

_____ _____
(Name of minor/dependent adult) (Date of birth)

_____ _____
(Name of minor/dependent adult) (Date of birth)

Please select the appropriate custodial arrangement that applies to your situation:

Check one

☐ Biological parents residing together
- Consent for treatment form can be signed by one biological parent

☐ Biological parents not residing together – sole custody agreement
- Consent for treatment form must be signed by the parent with sole custody

☐ Biological parents not residing together – joint custody agreement
- Consent for treatment form must be signed by ***both*** biological parents

_____ _____
(Signature of Custodial Parent / guardian) (Date)

_____ _____
(Signature of Custodial Parent / guardian) (Date)

_____ _____
(Signature of Witness) (Date)

Intake Questionnaire – Adult – Page 1

Today's Date: _____

Your Name: _____

Your Birthdate: _____ Age: _____

I am currently: □ Single □ Never married □ Widowed

(Check any that currently apply to you, even if more than one.)

□ Dating for _____ months / years
□ Cohabiting for _____ months / years
□ Married for _____ months / years
□ Separated for _____ months / years
□ Divorced for _____ months / years

Enter the time frame and circle "months" or "years".

Have you been married previously (not counting at present)?
□ Yes □ No If yes, how many times? _____

Do you have biological children of your own? □ Yes □ No
If yes, how many children do you have? _____
How many of your bio-children live with you? _____

Do you have step-children? □ Yes □ No
If yes, how many step-children do you have? _____
How many of your step-children live with you? _____

Education: *(highest level)*
□ Some high school □ High school
□ Technical / Trades □ 2-year associate degree
□ Some undergraduate college or university
□ Undergraduate degree □ Some graduate level
□ Graduate degree: _____

Income: *(household annual)*
□ $0-30,000 □ $31-60K □ $61-90K
□ $91-120K □$120-150K □ $150K +

Current Occupation: _____
Years at Current Job: _____ Hrs per week: _____
Do you enjoy your work? □ A lot □ Moderately □ Very little
Career Goals: _____

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none or not applicable, 1=a little, 2=moderate, 3=a lot, 4=extreme) rate how much you have experienced each symptom over **the past two weeks**.

(Circle a number)

1.	Feeling sad, down or depressed	0 1 2 3 4
2.	Avoiding certain people or places	0 1 2 3 4
3.	Loss of interest in activities I normally enjoy	0 1 2 3 4
4.	Low energy/feeling tired	0 1 2 3 4
5.	Sleep problems (insomnia, not staying asleep, or early waking)	0 1 2 3 4
6.	Eating too much or too little	0 1 2 3 4
7.	Not able to think clearly	0 1 2 3 4
8.	Feeling no pleasure or joy in life	0 1 2 3 4
9.	Anxiety attacks	0 1 2 3 4
10.	Worrying about things	0 1 2 3 4
11.	Angry outbursts	0 1 2 3 4
12.	Low self-esteem or low self-confidence	0 1 2 3 4
13.	Feeling guilty	0 1 2 3 4
14.	Feeling too stressed	0 1 2 3 4
15.	Thoughts of suicide	0 1 2 3 4
16.	Drinking too much or abusing drugs (i.e. street drugs or prescribed medications)	0 1 2 3 4
17.	Acting out other compulsive behaviors (i.e. gambling, sex, porn, shopping, etc.)	0 1 2 3 4
18.	Not getting my work done	0 1 2 3 4
19.	Feeling unhappy with my workplace	0 1 2 3 4

If you are in a relationship with a spouse, boyfriend, girlfriend or partner, please rate how much you have experienced each of these additional six symptoms in your relationship over **the past two weeks**. If you are single, circle all 0's in the next six statements and enter the total of 1 through 25 in the box below.

(Circle a number)

20.	Not talking to each other	0 1 2 3 4
21.	Having bad arguments	0 1 2 3 4
22.	Lack of trust between us	0 1 2 3 4
23.	Feeling lonely in the relationship	0 1 2 3 4
24.	Lack of affection and caring between us	0 1 2 3 4
25.	Feeling unhappy about our relationship	0 1 2 3 4
	Symptom Total (sum of all 25 symptoms)	**/ 100**

Medical: Do you have any medical problems? □ Yes □ No
If yes, please list them: _____
_____

Do you take any prescription **Medications**? □ Yes □ No
If yes, please list them:

Medication	*Dose*	*Purpose*	*Since*

Do you **Exercise**? □ Yes □ No If yes, what do you do?
_____

Do you drink **alcohol**? □ Yes □ No

If yes, estimate how many times you typically drink in a month (i.e. how many drinking occasions): _____

Estimate how many standard drinks you typically drink per occasion (estimate your range if it varies): _____

Do you **smoke** tobacco? □ Yes □ No
If yes, please estimate quantity per day: _____

Do you drink **coffee/ tea?** □ Yes □ No
If yes, please estimate quantity per day: _____

Do you use any **illicit drugs**? □ Yes □ No
If yes, please specify: _____

If you drink alcohol or use illicit drugs, please answer the following questions:

C. Have you ever thought you should **Cut down** on your drinking/ drug use? □ Yes □ No

A. Have people **Annoyed** you by criticizing your drinking/ drug use? □ Yes □ No

G. Have you ever felt bad or **Guilty** about your drinking/ drug use? □ Yes □ No

E Have you ever had a drink / used drugs in the morning (**Eye opener**) to steady your nerves or to get rid of a hangover? □ Yes □ No

Are you concerned about the alcohol and/or drug use of anyone close to you? □ Yes □ No If yes, who?
_____

In any of your <u>current</u> relationships, have you been:
Physically assaulted (hit, slapped, kicked, pushed, held down)?
□ Yes □ No If Yes, By? _____
The subject of demeaning, degrading comments or put downs?
□ Yes □ No If Yes, By? _____
Sexually abused or coerced into unwanted sexual activity?
□ Yes □ No If Yes, By? _____

In any of your <u>past</u> relationships, have you been:
Physically assaulted (hit, slapped, kicked, pushed, held down)?
□ Yes □ No If Yes, By? _____
The subject of demeaning, degrading comments or put downs?
□ Yes □ No If Yes, By? _____
Sexually abused or coerced into unwanted sexual activity?
□ Yes □ No If Yes, By? _____

REASONS FOR SEEKING COUNSELING

Check those that apply (*using the left column*). If you check more than one, please select your <u>top three</u> and rank them (*using the right column*) from highest to lowest in terms of the priority you place on resolving them (1=highest priority, 2=second highest, 3=third highest).

(√) (Check all that apply)	Rank
___ Depressed Mood	_____
___ Anxiety	_____
___ Anger Management	_____
___ Self-Esteem or Confidence	_____
___ Social Difficulties	_____
___ Stress Management	_____
___ Substance Abuse (Alcohol/Drugs)	_____
___ Gambling Difficulties	_____
___ Other Addictions (i.e. Porn, Sex, Shopping)	_____
___ Eating Disorder	_____
___ Weight Management / Body Image	_____
___ Spiritual Problems	_____
___ Bereavement/ Loss	_____
___ Work problems	_____
___ Education/ Career Concerns	_____
___ Financial Concerns	_____
___ Legal Concerns	_____
___ Medical Issues	_____
___ Domestic Violence or Abuse (Current)	_____
___ Premarital Counselling	_____
___ Communication Problems/Relationship Conflict	_____
___ Sexual Intimacy Concerns	_____
___ Emotional or Sexual Infidelity/affairs	_____
___ Emotionally disconnected from spouse/partner	_____
___ Other Marital/Relationship Concerns	_____
___ Separation / Divorce / Relationship Break-Up	_____
___ Custody Concerns	_____
___ Parenting	_____
___ Parent-Adult Child Relations	_____
___ Blended Family Issues	_____
___ Family Conflict	_____
___ Child – Behavioral Problems	_____
___ Child – Mood / Anxiety Problems	_____
___ Child – Academic Problems	_____
___ Child – Social/ Relational Problems	_____
___ Other _____	_____

PREVIOUS TREATMENT

Have you participated in therapy or counseling in the past?
□ Yes □ No If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

Who do you turn to for social support (e.g. for encouragement, advice, friendship, etc.)?

_____
_____
_____

Are there any organizations or agencies that you are currently receiving assistance or support from? □ Yes □ No If yes, please specify: _____
_____
_____

EXTENDED FAMILY HISTORY OF PSYCHOSOCIAL / HEALTH DIFFICULTIES

Please check any of the conditions below that are or have been present in your extended family. Please write any additional explanatory comments that may be helpful for your therapist to understand.

	Who? When?
□ Depression	_____
□ Bipolar Disorder	_____
□ Schizophrenia	_____
□ Other psychiatric disorders (i.e. psychosis, hallucinations)	_____
□ Suicide	_____
□ Physical / Sexual Abuse	_____
□ Substance Abuse (Alcohol/Drugs)	_____
□ Autism/Asperger's Syndrome	_____
□ Eating Disorder	_____
□ Chronic Illness (please specify illness)	_____
□ Accidental or Untimely Death	_____
□ ADHD or Learning Disorders	_____
□ Other	_____

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your therapist to know:

_____
_____
_____
_____
_____
_____

Intake Questionnaire – Child

Today's Date: _____
Child's Name: _____
Child's Birthdate: _____ Age: _____
Child's Biological Mother: _____
Child's Biological Father: _____

Child Primarily Resides With: □ Biological Mother and Father in same house □ Biological Mother □ Biological Father □ 50/50 Biological Mother & Father

Name of School: _____
Grade Level: _____
Average Grades: Math: _____
Science: _____
L.A.: _____
Social Studies: _____

Does your child have a job? □ Yes □ No
Current Job: _____
Years at Current Job: _____ Hrs per week: _____

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none, 1=rarely, 2=sometimes, 3=frequently, 4=many times) rate how much you have observed each symptom in your child over **the past year** (circle the number).

a. Withdrawal from family	0	1	2	3	4
b. Irritability or mood changes	0	1	2	3	4
c. Stealing	0	1	2	3	4
d. Lying	0	1	2	3	4
e. Loss of interest in extracurricular activities	0	1	2	3	4
f. Being secretive	0	1	2	3	4
g. Defying parents/house rules	0	1	2	3	4
h. Angry outbursts	0	1	2	3	4
i. Negative attitude to school	0	1	2	3	4
j. Drop in grades	0	1	2	3	4
k. Frequent change in friends	0	1	2	3	4
l. Worrying excessively	0	1	2	3	4
m Difficulties sleeping	0	1	2	3	4
n. Loss of drive/motivation	0	1	2	3	4
o. Difficulties making friends	0	1	2	3	4
p. Low self-image	0	1	2	3	4
			Symptoms Total:		**/ 64**

How much do these symptoms interfere with the following?

Personal well-being	0	1	2	3	4
School performance	0	1	2	3	4
Family relationships	0	1	2	3	4

Does your child:
Have any **Medical** problems? □ Yes □ No
If yes, please list them: _____
_____

Take any prescription **Medications**? □ Yes □ No
If yes, please list them:

Medication	*Dose*	*Purpose*	*Since*

Do any **Extracurricular** Activities? □ Yes □ No
If yes, please specify: _____
_____
_____

Are you concerned that your child is using alcohol and/or illicit drugs? □ Yes □ No

Has your child ever threatened self-harm? □ Yes □ No
If yes, when? _____

Has your child experienced any past **trauma**? □ Yes □ No
If yes, please specify: _____
_____
_____
_____

PREVIOUS TREATMENT

Has your child participated in therapy or counseling in the past? □ Yes □ No If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your therapist to know:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank-you very much for taking the time to fill out this questionnaire.