

# THE ROSS CENTER

## Acknowledgement of Therapist–Client Agreement and HIPAA Notice

With my signature below, I acknowledge that I have read the “Therapist–Client Services Agreement” available on The Ross Center’s website at [www.NashvilleCounseling.org](http://www.NashvilleCounseling.org), understand its content, and agree to abide by the terms therein:

- I. Counseling Services
- II. Appointments
- III. Limits on Confidentiality
- IV. Clinical Records
- V. Minors and Parents
- VI. Professional Fees
- VII. Billing and Payments
- VIII. Insurance Reimbursement
- IX. Emergencies

I also acknowledge that I have received a copy of the “Notice of Privacy Practices and Patient Rights” as required by the Health Insurance Portability and Accountability Act (HIPAA), and I understand the circumstances under which my Protected Health Information (PHI) can be disclosed.

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Signature

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Date

## CHILD AND ADOLESCENT INTAKE FORM

To be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand you child. It, as all communications with your therapist, will be kept confidential to the full extent of Georgia law.

### BACKGROUND INFORMATION

Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Child lives with (✓ one):    both biological parents \_\_\_\_\_ mother \_\_\_\_\_ father \_\_\_\_\_  
                                         mother & stepfather \_\_\_\_\_ father & stepmother \_\_\_\_\_ other \_\_\_\_\_

If parents are divorced, describe custody arrangements: \_\_\_\_\_  
\_\_\_\_\_

Child's Address/City/St/Zip \_\_\_\_\_

Child's Home Phone \_\_\_\_\_

Emergency Contact Person (other than parent) \_\_\_\_\_ Phone Number \_\_\_\_\_

### INFORMATION ABOUT CHILD'S MOTHER

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Hrs/wk \_\_\_\_\_

Employer's Address \_\_\_\_\_

Can you be contacted at work by phone?    Yes    No            Work phone \_\_\_\_\_            ext \_\_\_\_\_

Denomination \_\_\_\_\_ Church \_\_\_\_\_ Active?    Yes    No

Describe any physical problems you have that require medication or physical care? \_\_\_\_\_  
\_\_\_\_\_

Are you currently receiving medical treatment?    Yes    No            Physician \_\_\_\_\_

Medication(s) currently using \_\_\_\_\_

Previous Counseling / Therapy?    Yes    No    If yes, when? \_\_\_\_\_

With whom and for how long? \_\_\_\_\_

### INFORMATION ABOUT CHILD'S FATHER

Father's Name \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Hrs/wk \_\_\_\_\_

Employer's Address \_\_\_\_\_

Can you be contacted at work by phone?    Yes    No            Work phone \_\_\_\_\_            ext \_\_\_\_\_

Denomination \_\_\_\_\_ Church \_\_\_\_\_ Active?    Yes    No

Describe any physical problems you have that require medication or physical care? \_\_\_\_\_  
\_\_\_\_\_

Are you currently receiving medical treatment?    Yes    No            Physician \_\_\_\_\_

Medication(s) currently using \_\_\_\_\_

Previous Counseling / Therapy?    Yes    No    If yes, when? \_\_\_\_\_

With whom and for how long? \_\_\_\_\_

**FAMILY MEMBERS**

List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime:

Name	Relationship to Child	Age	Highest School Grade Completed	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**DESCRIBE THE PROBLEM** If possible, list questions for which answers are sought: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Problem Areas: In the following list, place a check mark (✓) next to each item which identifies an area of concern to you. Place 2 check marks (✓✓) by those items which are most important. (You may add written comments after areas checked.)

- |       |                                    |       |                          |
|-------|------------------------------------|-------|--------------------------|
| _____ | Anger / Temper                     | _____ | Sexual Concerns          |
| _____ | Depression                         | _____ | Thoughts of Suicide      |
| _____ | Education                          | _____ | Trouble making decisions |
| _____ | Family Problems                    | _____ | Unhappy most of the time |
| _____ | Fearfulness                        | _____ | Use of Alcohol           |
| _____ | Marital Problems                   | _____ | Use of Drugs             |
| _____ | Physical Problems                  | _____ | Work                     |
| _____ | Problems with Social Relationships | _____ | Worry                    |
| _____ | Problems with Children             | _____ | Other (specify) _____    |
| _____ | Religious / Spiritual Concerns     | _____ | _____                    |

**MEDICAL HISTORY**

List child's sickness, operations, and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:

\_\_\_\_\_

\_\_\_\_\_

Have there been any previous psychological, psychiatric, neurological, or EEG evaluations?    Yes    No

If so, please list names, addresses, and dates of contact: \_\_\_\_\_

Indicate any continuing medication treatment: \_\_\_\_\_

How is child's vision? \_\_\_\_\_

How is the child's hearing? \_\_\_\_\_

Describe previous speech or hearing therapy, if any: \_\_\_\_\_

When did your child last have a physical examination? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

**ACADEMIC / SCHOOL INFORMATION**

School Name \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

List previous schools attended with dates: \_\_\_\_\_

Has child ever repeated a grade? Yes No If so, when? \_\_\_\_\_

How does your child get along at school? \_\_\_\_\_

Describe difficulties in learning at school: \_\_\_\_\_

Have other family members had learning difficulties? \_\_\_\_\_

Describe what your child likes to do for fun, special interests, hobbies, etc. \_\_\_\_\_

Describe your child's religious background (religious denomination, is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_