COUNSELING INTAKE FORM Phone: (907) 206-6433

Please Submit Completed Forms to The Talking Place

Fax to: (907) 759-5170

Email to: office@thetalkingplace.org

Patient Demographic & Contact Information

Today's Date_______________

First Name___________________ MI______ Last Name_________________ Preferred Name_____________________

DOB_____________ SSN _______________ Patient Legal Gender__________Patient Preferred Gender_______

Marital Status __________________ Phone Number_________________ ☐ Cell ☐ Home ☐ Work **Ok to text?** ☐ **Y** ☐ **N**

Mailing Address_________________________________ City__________ State_______ Zip Code__________________

Email Address________________________ Occupation __________________ Employer__________________________

Emergency Contact Name_________________ Relationship_______________ Phone Number ____________________

How were you referred into our office? ____

Primary Contact Information

First Name___________________ MI______ Last Name_________________ Preferred Name________________

Relation to Patient________________________

DOB_____________ SSN _______________ Marital Status _______ Male _____ Female ______

Phone Number_________________ OK to leave a message? Y_____ N______ OK to text? Y_________N________

Mailing Address_________________________________ City__________ State_______ Zip Code__________________

Email Address________________________ OK to email? Y_____ N______ Occupation/Employer _________________

Secondary Contact Information

First Name___________________ MI______ Last Name_________________ Preferred Name________________

Relation to Patient________________________

DOB_____________ SSN _______________ Marital Status _______ Male _____ Female ______

Phone Number_________________ OK to leave a message? Y_____ N______ OK to text? Y_________N________

Mailing Address_________________________________ City__________ State_______ Zip Code__________________

Email Address________________________ OK to email? Y_____ N______ Occupation/Employer _________________

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Insurance Information

Primary Insurance Company ____________________________ Phone Number _________________________________

Policyholders Full Name ___________________________ Policyholders DOB __________________________________

Policyholders SSN ___________________________________ Employers Name _______________________________

Subscriber ID Number ______________________________ Group Number ___________________________________

Secondary Insurance Company ____________________________ Phone Number _______________________________

Policyholders Full Name ___________________________ Policyholders DOB __________________________________

Policyholders SSN ___________________________________ Employers Name _______________________________

Subscriber ID Number Group Number

Patient Medical Information

Primary Care Physician _________________ Phone Number_________________ Date of Last Visit_________________________________

Psychiatrist ____________________ Phone Number _______________________ Date of Last Visit_________________________________

Current Medical Conditions/ Any major hospitalizations? ____

Current Medications & Dosage ☐ **Allergies** if so Please List: ____

Current Medication	Dose	Reason for Taking Medication	Prescribing Doctor

Birth and Development

Birth Weight of Patient ___________Any complications during pregnancy or delivery? ____________________________________

Any feeding and sleeping problems?______________ Where was the patient born? ____

Were early motor milestones met within expected age ranges?____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of the above given information.

Signature/ Parent Legal Guardian Signature __________________________ Today's Date___________________________

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Confidential Personal & Family Information

***Please elaborate in detail to the best of your ability the below requested information, as it helps the counselor attain much needed information in regards to the patient.*

Person Completing the Form_________________________ **Relationship to Patient**___________________________

Family Dynamic

Primary Residence:

Please list any adults and their relation to the patient who live inside the family home ___________________________

____

Please list any children, their age, and their relation to the patient who live inside the family home________________

____

Please list any pertinent adult and their relation to the patient who resides outside the family home_______________

____

Please list any pertinent child, their age, and their relation to the patient who resides outside the family home

____

Are there any custody issues, if so please explain? ____

____

Major Concerns you would like counseling to address: ____

____

What do you think the causes may be? ____

____

What solutions have been attempted, and worked best? ____

____

What solutions have been attempted, and did NOT work? ____

Have you consulted anyone else about your concerns? (e.g., counselor, physician, minister, teacher)________________________

____

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Please check any of the following which apply to your child's health history and indicate the age at which it occurred.

☐ Allergies _______	☐ Fainting _______	☐ Migraine Headaches _______
☐ Anemia ________	☐ Head Injury _______	☐ Emotional Problems _________
☐ Asthma __________	☐ High Fevers ________	☐ Seizures __________
☐ Colic as a baby ______	☐ Overly Active ________	☐ Hearing Problems _______
☐ Dizziness _______	☐ Concussion _________	
☐ Ear Infections _______	☐ Diabetes __________	

Behavioral Health History

Behavioral Health: Has the Patient Been Formally Diagnosed with Any of the Following:

☐ ADD ☐ ADHD ☐ Anxiety ☐ Autism ☐ Depression ☐ Eating Disorder ☐ OCD ☐ Bipolar Disorder

☐ Post Traumatic Stress Disorder ☐ Schizophrenia & Schizoaffective Disorders

Any Other Behavioral Diagnosis We Should Know About ____

____

Has anyone in the patient's immediate family been diagnosed with any behavioral health issues (e.g. depression, anxiety, bipolar), and if so who?____

____

Has anyone in the patient's extended family attempted suicide, if so who?____

____

Has the patient ever been hospitalized for any behavioral health issues? _______________________________________

____

Has the patient ever been arrested, if so please elaborate? ____

____

Has anyone in the immediate household ever been arrested, if so please elaborate?__________________________________

____

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Child Social Interactions

Please check if the patient currently OR has ever exhibited these behaviors.

□ Bed Wetting □ Eating problems □ Fire Setting □ Overly Conscientious □ Thumb Sucking □ Physical Complaint □ Tics □ Moody

□ Poor Academic Grades □ Sexual Problems □ Temper Tantrums □ Withdrawing from Friends/Family □ Shy □ Fighting

□ Does Not Follow Directions □ Clings to Parents □ Excessive Crying □ Forgetful □ Harmful to Animals □ Poor Bowel Control

□ Speech Problems □ Destructive □ Fear and Worries □ Daydreams □ Lying □ Nail Biting □ Poor Coordination □ Restless

□ Sleeping Problems □ Trouble Getting Along w/ Adults □ Trouble Getting Along w/ Children □ Misuse of Drugs or Alcohol

□ Overactive □ Suicide Attempt □ Dislikes School □ Stealing □ Nervous

What school does the patient attend? ____________________ What grade are they in? ____________________

Who is their teacher?____________________ What is their academic performance like? ____________________________________

Does the patient take any Special Education Classes or have an IEP? □ Yes □ No

If so please elaborate____

Has the patient ever skipped a grade? If so what grade?____

Has the patient ever repeated a grade? If so what grade?____

Are there any disciplinary problems at school? ____

Please list the schools your child has attended.

School ____________________ Grade___________________ How did they do?____________________________________

School ____________________ Grade___________________ How did they do?____________________________________

School ____________________ Grade___________________ How did they do?____________________________________

Has there been any major changes in their report card at school, or recent behavioral issues?_________________________________

____

What are their hobbies?____

What are their favorite toys/ video games/ books etc.? ____

What are their favorite foods? ____

What three characteristics do you like best about your child? ____

What three characteristics do you most want to see changed?____

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Social Interactions

To be filled out by patients who are 13 and older

What are your primary reasons for seeking counseling? ____

____

What characteristics would you like counseling to help you with?____

____

What are current stressors in your life?____

____

Are you currently employed? □ Y □ N

If so where? ___________________ Full or Part Time?_____________

Are you currently in school? □ Y □ N

If so where? ___________________ Full or Part Time?_____________

Highest level of schooling completed? ____

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******To Be Filled Out by the Child***

Today's Date_______________

Full Name___________________________ Age __________________________ Grade ________________________

Please circle any of the following that are troubling you:

Divorce Jealousy Stubbornness Brother/Sister Headaches Sleep Trouble Guilt Appetite Friends

School Boyfriend/Girlfriend Withdraw Making Decisions Self-Control Lying Temper Cheating (at school)

Shyness Feeling Alone Family Conflict Weight Loss/Gain Low Self-Esteem Anger Health Problems Sex Problems

Suicidal Thoughts/Feelings Doing Things Over & Over Short Attention Span Aggressive Feelings Anorexia Hate

Physical Fighting Can't be Alone Being Uncooperative Feeling Disorganized Sexual Identity Defiance Teachers

Skipping School Teasing Depression Alcohol/Drug Use Stress Sexual Abuse Unhappiness Grief (due to recent loss)
Panic Attacks Sleep Too Much Can't Relax Can't Concentrate Destructive Behavior Sadness Loneliness
Restlessness Fears Nightmares Energy Level

Anything else helpful to your counselor that is not listed above?____

How do you hope counseling will help you? ____

What are things that make you happy?____

What are things that make you upset? ____

What do you like to do in your free time? ____

What are your favorite classes in school? ____

What are your least favorite classes in school? ____

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Telemental Health or Distance Therapy Informed Consent

Telemental Health or Distance Therapy is the provision of mental health services between a provider and patient who are not in the same location over electronic communications (audio, video or other electronic communications). It can provide an efficient and effective way to engage in therapy, which has traditionally occurred face-to- face in office settings. The following summarizes the information you need to know in order to determine whether you wish to supplement your experience of therapy through telemental health:

Risks:
Telemental heath is a new delivery method for mental health services and is not fully validated by research. There may be potential risks, including some that are not currently recognized. The known risks include the possibility the technology can fail during the session, the transmitted information could be unclear or inadequate due to technical issues, and the information could potentially be intercepted by unauthorized person(s). It is also possible that the security protocols could fail, resulting in a breach of privacy of personal health information (PHI). To the extent that The Talking Place, Child and Adolescent Counseling, LLC is able, telemental health sessions will be considered and treated with the same degree of privacy and confidentiality as in-office sessions. However, telemental health has some limits to confidentiality as a result of the electronic means required to provide the service. There are risks in electronic transmission of information including but not limited to breaches of confidentiality, theft of PHI and disruption of sessions due to technical difficulties.

Location: The Talking Place, Child and Adolescent Counseling, LLC provides mental health services from the above indicated location(s). All of our providers are licensed to practice in Alaska and this practice is limited to patients in the state of Alaska at this time.

Records: In accordance with state law, patient records are maintained and archived for a period of seven (7) years following the termination of counseling as identified by the last therapeutic session of record.

Limits of Confidentiality: Confidentiality is defined in the clinic policies and procedures.

Potential Limits Impacting Service Delivery: When providing distance therapy services, a variety of issues may impact service delivery. These include, but are not limited to: time zone differences (we are located in the Alaska Time Zone, GMT-9), differences in local customs, cultural and language differences. Insurance for Telemental Health or Distance Therapy: In 2016, Alaska enacted a law expanding the use of telemedicine in the state. This law authorizes the use of telemedicine (also known as telemental health and distance therapy) in certain clinical practices, including counselors. In addition, a law was enacted requiring insurance plans in Alaska to cover telemental health services the same as in-person mental health services and without the need for a prior in person visit between the health care provider and the patient. **However, it is your responsibility to determine if outpatient mental health and telemental health services are covered by your insurance plan. Ultimately you are responsible for any balance not covered by your insurance.**

Emergency or Crisis Procedures: I understand my provider and I will regularly reassess the appropriateness of continuing to deliver services through the use of the technologies in the provision of my care and we will modify our plan as needed. I understand that as a result of the distance involved, some therapeutic interventions that my provider might provide in-person may not be available. I also recognize my provider will not be able to render any emergency assistance if I experience a crisis.

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Tele-mental Health Signature Page

In emergencies, in case of service disruption or for other routine administrative purposes, it might be necessary to communicate by other (non-Zoom) means:

Patient alternative contact in emergency situations (facetime, skype, phone number etc.): ______________________________________
____

Patient alternative contact in non-emergency situations (if different): ____
____

I acknowledge that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or another person, I agree to seek care immediately though my own health care provider, at the nearest hospital emergency department or by calling 911.

Here are the names and telephone numbers of my local emergency contacts (including local physician, crisis line, trusted family, friend and/or advisor):

____ _____________________________ Name and relationship
Telephone Number

____ _____________________________ Name and relationship
Telephone Number

____ _____________________________ Name and relationship
Telephone Number

If a need for direct, in-person services arises, it is my responsibility to contact my mental health providers office for an in-person appointment or my primary care physician if my mental health provider is unavailable I understand that an opening may not be immediately available in either office, or that due to distance involved, it might be more appropriate for me to seek emergency care. Emergency care providers in my area that I could contact include:

____ _________________________________
Name of emergency care provider Telephone Number

I have discussed local support services that may be available in case of emergency. I am aware my provider may contact the proper authorities and/or my designated local contact persons in case of an emergency. I acknowledge that I have read and understood the above description of risks and responsibilities involved with telemental health participation.

With this knowledge, I voluntarily consent to participate in telemental health treatment.

Authorized Email Address (Please Print):____

Authorized Phone Number to Call and/or Text:____

Printed Patient Name:____

Patient Signature:____ **Date:**________________

Parent/Guardian Signature if Patient is a Minor:____

Parent/Guardian Printed Name:____ **Date:**________________