

COUNSELING INTAKE FORM

Phone: (907) 206-2166

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 _____

The Talking Place, Child & Adolescent Counseling, LLC
 17101 Snowmobile Ln. Suite 109
 Eagle River, Alaska 99577
 Updated: 2/28/25

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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 _____
- Anemia _____
- Asthma _____
- Colic as a baby _____
- Dizziness _____
- Ear Infections _____
- Fainting _____
- Head Injury _____
- High Fevers _____
- Overly Active _____
- Concussion _____
- Diabetes _____
- Migraine Headaches _____
- Emotional Problems _____
- Seizures _____
- Hearing Problems _____

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 health 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 through 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:** _____