

Intake Forms

Parent/Guardian Information Form

Mother: _____ Email Address: _____

Father: _____ Email Address: _____

Communication:

Home Phone: _____ FAX: _____

Mother Work Phone: _____ Cell: _____

Father Work Phone: _____ Cell: _____

Mailing Address: _____

Date of Parent's Marriage: _____

Mother's Separation(s): _____ Divorce(s): _____

Father's Separation(s): _____ Divorce(s): _____

Siblings Name	Age	B/A/F	Mental Health (Briefly describe)
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Caseworker: _____ Phone: _____

Agency: _____ Phone: _____

Child's Information

Child _____ Date of Birth _____

Chief Complaint and Problem: _____

Referred by: _____ Phone: _____

Sex: Male Female Adopted, Foster, Birth child? _____ Place of Birth _____

If adopted, date placed in home: _____

School: Grade: _____ Teacher: _____ School Therapist: _____

Name of school: _____ Phone: _____

Functioning: Average, Above Average, Below Average, Could do Better Tested IQ: _____

Therapy History:

Therapist: _____ Length of Treatment: _____ Type: _____

Therapist: _____ Length of Treatment: _____ Type: _____

Current Therapist: _____ Phone: _____ Email: _____

FAX: _____ Length of Treatment: _____ Type: _____

Previous Diagnoses: _____

Current Diagnoses: _____

Psychotropic Medication trials: (What has been tried, what dosage, how long, dates, when given)

Current Psychotropic Medications: (What dosage, when started, when given)

Attach previous reports, treatment summaries, histories, psychological evaluations etc. from schools, doctors, therapists, caseworkers, etc. (Please do not include all of them. Just send those you believe are the most informative, useful and recent.)

Does your child make false allegations? If yes, please describe the last three incidents.

Date: _____ Who: _____

Description of incident:

Date: _____ Who: _____

Description of incident:

Date: _____ Who: _____

Description of incident:

Violence and destructive behavior

Violence is the deliberately hurting/harming a person/animal (e.g., killing insects, injuring pet/sibling). Destructive is the deliberate act of destroying property (e.g., punching holes in walls). Please describe the last 3 violent or destructive acts that your child committed.

Date: _____ Who/What: _____

Description of incident:

Date: _____ Who/What: _____

Description of incident:

Date: _____ Who/What: _____

Description of incident:

Medical History Form

Date of last physical examination: _____ Height: _____ Weight: _____

Allergies: _____

Any significant medical problems? If yes, please send record to Deborah Hage, P.O. Box 42, Silverthorne CO 80498. Briefly explain _____

Medication history (include diagnosis, dosage, side effects, response to medication):

Surgeries/Accidents: _____

Any limitations to physical activities? _____

Seizures? _____ Type: _____ Frequency: _____ Duration: _____

Suspected alcohol/drug use? _____

Physician Information:

Name: _____

Address: _____

Phone: _____

Record of Child's Out of Home Placements

Record as much information as you can. Begin with the current or most recent placement and work back.
Use additional forms if needed.

Dates: _____

Type of Placement (birth, birth relative, adopt, foster, step, institution, residential) _____

Reason for move: _____

Child's feelings: _____

Caretaker name: _____

Other information: _____

Dates: _____

Type of Placement (birth, birth relative, adopt, foster, step, institution, residential) _____

Reason for move: _____

Child's feelings: _____

Caretaker name: _____

Other information: _____

Dates: _____

Type of Placement (birth, birth relative, adopt, foster, step, institution, residential) _____

Reason for move: _____

Child's feelings: _____

Caretaker name: _____

Other information: _____

Dates: _____

Type of Placement (birth, birth relative, adopt, foster, step, institution, residential) _____

Reason for move: _____

Child's feelings: _____

Caretaker name: _____

Other information: _____

Parent-Child Relationships

Responsiveness (particularly to the Mother)

Describe your child's eye contact with the Mother.

Describe any reciprocity the child has with the Mother.

How does your child respond to the Mother's touch?

How well does the child accept affection on the parent's terms?

Internalization of Parental Figure

How well does your child stay where he/she is put?

How well does your child interact with other children his/her own age?

Describe the fears your child has. This may include new situations, nightmares, etc.

Generalization of Parent-child Relationships to Other Authority Figures

Describe how well your child does in different school situations, especially those that seem to cause problems.

Describe your child's peer relationships at school.

What type of peers does your child tend to choose?

How long do the peer relationships last?

Are the peer relationships age appropriate?

BIOGRAPHY OF CHILD

Please write your child's biography covering the following areas and any other events you know which were/are significant in his/her life. There is much you will not know, however, everything you do know will make our therapeutic task easier as history is a pivotal part of brain and personality development. Having this information in advance will allow us to save valuable time on the first day of treatment as we won't have to spend hours just getting an accurate history.

1. Describe birth mother (anything known, include both strengths and weaknesses, DOB/age, name, anything known about her early history, relationship with parents, where she is now)
2. Describe birth father
3. Describe birth parents' marital/sexual/alcohol/drug/mental illness history.
4. Describe other birth siblings. Give names, dates of birth, where the children are now, interactions the siblings had with your child.
5. Describe your child's early childhood. Include any illnesses, hospitalizations, injuries, interactions/interventions by DHS (Please include copies of any original reports you have.)
6. Include the following dates:
 - Foster/orphanage placements, names of significant people
 - Placement with present family, Finalization of adoption
 - Termination of birth parental rights
 - Any hospitalizations and out of home placements
 - Began therapy and with whom
 - Subsequent contacts with other therapists
7. Since placement with you describe and date any significant problematic behaviors, what the child did, who was involved

"A Day in the Life of Your Child"

Please give a written description of a typical day in the life of the child you are bringing for treatment, with the following information as a guideline. Describe a typical day in the life of your child, including those negative behaviors, which necessitate treatment.

- Describe how you would typically respond to these behaviors.
- Describe how your child would typically respond to your response or attempt to set limits.
- In general, what is your child's response to authority?
- Which of your child's behaviors bother you the most?
- What kind of control hassles come up. Be specific. Who wins? How long does it take?
- What behaviors are the most difficult to manage? Destructive? Dangerous?
- Describe the interaction between your child and siblings. Between your child and peers.
- Describe your child's school behavior. What specific behaviors in school are problems.
- Describe the community's (teachers, neighbors, friends, family) reactions to your child's behavior and to your parenting interventions.
- Describe how your child relates to mother. To father.
- For each member of your family, describe what impact this child has had on your:
 - Marriage, Family, Lifestyle, Personal well being
- Does anyone in the family feel threatened? In what way?
- Which of your parenting techniques seems to be the most effective? The most ineffective? What have you tried?
- How are you feeling? (Answer for each member of the family).
- What are your worst fears? What are your best hopes?

Parent/s Background

1. Describe your parenting philosophy.
2. Describe your means of motivation/discipline.
3. Describe any differences in your parenting styles.
4. Describe your communication styles.
5. How are decisions made?
6. Describe the family's support system.
7. Describe your family's involvement in outside activities.
8. How large of a role (if any) does religion play in your family?
9. How does child with behavioral and emotional issues impact the other children in the home?

Detailed Symptoms Form

Please answer all questions. Beside each item below, indicate the degree of the problem with an "X"

	Not at all	Just a little	Pretty much	Very much
Picks at things (nails, fingers, hair, clothing...)				
Sassy to grown-ups				
Problems with making or keeping friends				
Excitable, impulsive				
Wants to run things				
Sucks or chews (thumb, clothing, blankets...)				
Cries easily or often				
Carries a chip on his/her shoulder				
Daydreams				
Difficulty in learning				
Restless in the "squirmy" sense				
Fearful (of new situations, new people or places, going to school...)				
Restless, always on the go				
Destructive				
Tells lies or stories that aren't true				
Shy				
Gets into more trouble than others same age				
Speaks differently from others same age (baby talk, stuttering, hard to understand...)				
Denies mistakes or blames others				
Feels cheated in family circle				
Boasts and brags				
Lets self be pushed around				

Bowel problems (loose, irregular, constipated)				
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Detailed Symptoms (cont)

	Not at all	Just a little	Pretty much	Very much
Quarrelsome				
Pouts and sulks				
Steals				
Disobedient or obeys resentfully				
Worries more than others				
Fails to finish things				
Feelings easily hurt				
Bullies others				
Unable to stop a repetitive activity				
Cruel				
Childish or immature (wants help he shouldn't need, clings, needs constant reassurance)				
Distractibility to attention span problem				
Headaches				
Mood changes quickly and drastically				
Doesn't like or doesn't follow rules or restrictions				
Fights constantly				
Doesn't get along well with brothers or sisters				
Easily frustrated in efforts				
Disturbs others				
Basically an unhappy child				
Problems with eating (poor appetite, gorges)				
Stomach aches				
Problems with sleep (can't fall asleep, up to early, up at night...)				
Other aches and pains				
Vomiting or nausea				

Consent for Release of Confidential Information
(Copy as many times as necessary)

I/we, _____, do hereby authorize Deborah Hage to release unto and receive from

professional information in regard to _____.

I understand that my records are protected under the Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance to it. Specification of the date, event or condition upon which this consent expires:

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

Notice to Recipient of disclosed information:

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal Regulations (42 CFR, Part 2) prohibits you from making any further disclosure of it without specific written consent from the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Deborah Hage, MSW
PO Box 42
Silverthorne, CO 80498
970-262-2998

DISCLOSURE STATEMENT

Highest Degree MSW (Master of Social Work), University of Denver, 1996
Clinical Internship Inn at Chicago Creek, residential treatment for children
Licensure Unlicensed therapist

REGULATION OF PSYCHOTHERAPY

The Colorado State Department of Regulatory Agencies has the general responsibility of regulating the practice of Licensed Psychologists, Licensed social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and unlicensed psychotherapists. The agency within the Department that has specific responsibility for psychotherapists is the COLORADO STATE BOARD OF PSYCHOLOGIST EXAMINERS, 1560 Broadway, Suite 1340, Denver, CO 80202; 303-894-7766. If you believe that a client of mental health services has been harmed by those services (for example, harmful activities in the Colorado Revised Statutes 12-43-704), a grievance can be filed with the Colorado State Board of Psychologist Examiners.

CLIENT RIGHTS AND IMPORTANT INFORMATION

INFORMED CONSENT: You are entitled to receive information from me about my methods of therapy, techniques used, and the duration of therapy (if that can be determined), and my fee structure.

SECOND OPINION: You may seek a second opinion from another therapist or terminate therapy at any time.

SEXUAL CONTACT: Sexual intimacy between a therapist and a client is never appropriate. If it occurs, it should be reported to the State Board.

CONFIDENTIALITY: Communications with a psychotherapist, including a certified school psychologist, are confidential and cannot be disclosed by the therapist, as provided by law, with certain exceptions (Colorado Revised Statutes 12-43-218). Disclosure requires client consent.

SOME EXCEPTIONS TO CONFIDENTIALITY:

SUSPICION OF CHILD ABUSE: A therapist is required to report the suspicion to the police and the local department of Social Services, so that an investigation can take place.

IMMINENT DANGER: If a client is imminently SUICIDAL or GRAVELY DISABLED due to a mental illness, the therapist is required to disclose relevant information to persons in a position to protect the client.

THREATS OF IMMINENT AND SEVERE BODILY HARM to a third party by a client requires that the therapist attempt to warn the intended victim.

LITIGATION: Disclosure without client consent may be required when the mental health of a the client is at issue is a court proceeding. Such proceedings include criminal, dependency and neglect, personal injury, and child custody proceedings.

_____	_____	_____	_____
Client and/or Guardian	Date	Deborah Hage, MSW	Date
Persons intended to be included in the psychological services:			
NAME	Birth Date		

Reasons for evaluation or psychotherapy: