Paraclete
Counseling Center, Inc.

This form will enable us to gain a quicker understanding of your child and it will become a part of their confidential file. Please answer each question as completely as possible.

Date_____

Part I: Child

Child's name_____
First Middle Last

Address_____
City State Zip

Cell Phone_____School_____Grade_____

Child's Birth date_____ Age_____Sex_____

Height _____ Weight _____

Pediatrician/Primary Care Physician_____

Address_____Phone_____

Current Medications (list all including vitamins and herbal supplements)_____
_____

Person completing this form_____

Part II: Parents

Mother's name_____Birthdate_____

Address(If different from Child) _____

Home phone_____Cell phone_____

Occupation_____ Work phone_____

Father's name_____ Birthdate_____

Address (if different from Child) _____

Home phone_____ Cell phone_____

Occupation_____ Work phone_____

Parent's marital status: Married _____ Divorced _____ Separated _____
Never married _____ Remarried _____ How long? _____Other_____
Date of Divorce _____ Date of Remarriage_____

Part III: Family Members

List all people Name/Age/Relationship to Client

_____

_____

_____

Who has legal custody? Mom _____ Dad _____ Joint _____ Other _____

Who has physical custody? Mom _____ Dad _____ Joint _____ Other _____

Stepparent's name_____ Birth date _____

Home Phone_____ Cell phone _____

Stepparent's name_____ Birth date _____

Home Phone_____ Cell phone _____

Who gave you our name? _____

May we have your permission to thank this person for your referral? Yes No

Religious Affiliation_____Church_____

Parents Active _____ Inactive_____ Child Active _____ Inactive_____

Part IV: Financial

If you have any financial questions or concerns about your fee, please talk to your therapist. Fees are due at time of service. You may use cash, check, debit cards, Visa, MasterCard or Discover.

Who is financially responsible for these fees?_____

We will file your claims with your insurance company if you have out-of-network benefits.

Primary Insurance Company_____

Phone Number of Insurance Company_____

Policy #_____ Group # _____

Insured's Name _____ Insured's Date of Birth _____

I, the undersigned, do authorize the release of any medical information necessary to process claims. I hereby assign payments directly to Paraclete Counseling Center and the supervisors thereof of the benefits as well as major medical benefits herein specified, and otherwise payable to me under the terms of my insurance. I understand that I am financially responsible to the clinician for charges not covered by this agreement. I hereby authorize photocopies of this form to be as valid as the original. Signed this _____ day of _____, 20_____; in the city of _____, situated in _____ County, state of Georgia.

Signed_____ Date_____

Psychosocial History

Part V: Development

Please fill in any information you have on the areas listed below.

□ Prenatal medical illness_____

_____

□ Premature Birth_____

□ Birth Complications_____

Check any problems during 1st year of life:

□ Allergies _____

□ Sleep patterns or problems_____

□ Any other medical problems_____

_____

□Developmental Issues_____

Part VI: Health

Check any:

□ Major childhood illnesses □ Hospitalizations □Medications □ Allergies □ Head trauma

□ Important accidents and injuries □Surgeries □ Periods of loss of consciousness

□ Convulsions/seizures □ Other medical conditions

Please list age and explanation below:_____

_____

_____

Is your child currently taking any medication □ yes □ no. If yes, please list_____

_____

Please list any special classes or therapies attended currently or in the past_____

_____

Have there been any previous psychological, psychiatric, neurological or EEG evaluation?

□ yes □ no If yes, list provider and dates of service_____

_____

Has child had previous counseling? □ yes □ no If yes, please list name of counselor and date of contact_____

Part VII: Residences

1. Homes - please list all dates that the child has lived in different residences, including location, who they were living with, their reason for moving, and any problems.

_____

_____

_____

2. Residential placements, institutional placements, or foster care - if applicable, please list dates that the child was placed in a home, the program and location, the reason for the placement, and any problems.

_____

_____

_____

Part VIII: Schools

Current school and grade: _____

Describe difficulties in learning at school_____

_____

_____

Part IX: Special skills or talents of child

List hobbies, sports, recreational interests, TV, and toy preferences, etc_____

_____

Part X: Other

Is there anything else I should know that doesn't appear on this or any other forms, but might be important?_____

_____

_____

_____

Concerns Checklist

1. _____ Anger/Temper
2. _____ Depression
3. _____ Divorce/Separation of Patents
4. _____ Adjustment of Parent's Remarriage
5. _____ Physical or Sexual abuse
6. _____ School Performance
7. _____ Family Problems
8. _____ Conflict with Siblings
9. _____ Fearfulness
10 _____ Physical Problems
11._____ Problems with Social Relationships
12._____ Sleep Problems
13._____ Nightmares
14._____ Sexual Concerns
15._____ Religious/Spiritual Concerns
16. _____ Talk of Suicide
17. _____ Unhappy Most of the Time
18. _____ Use of Alcohol
19. _____ Use of Drugs
20. _____ Worry
21. _____ Self Esteem
22. _____ Poor Appetite
23. _____ Over Eating
24. _____ Bedwetting
25. _____ Soiling
26. _____ Cruelty to Animals
27. _____ Fire Setting
28. _____ Problems with concentration
29. _____ Grief/death of loved one

Below you will find statements about your child and any symptoms he or she may be experiencing. Circle the number below the word that best describes your child's behavior during the last 3 months. Please write under the statement any additional information that you feel would be helpful.

	Never	Sometimes	Often	Always
1. My child continually seeks attention.	0	1	2	3
2. I can see tension building up in my child.	0	1	2	3
3. My child explodes under stress.	0	1	2	3
4. My child has nervous habits, like pulling at his/her clothing, clearing his/her throat, sniffing his/her nose, etc.	0	1	2	3
5. My child cries easily.	0	1	2	3
6. My child sucks his/her thumb or finger.	0	1	2	3
7. My child rocks back and forth.	0	1	2	3
8. My child shakes and trembles.	0	1	2	3
9 . My child is moody.	0	1	2	3
10. My child becomes overexcited easily.	0	1	2	3
11. My child is hyperactive and restless.	0	1	2	3
12. My child becomes hysterical, upset, or angry when things do not go his/her way.	0	1	2	3
13. My child seems sad.	0	1	2	3
14. My child walks or talks in his/her sleep.	0	1	2	3
15. My child gets confused easily.	0	1	2	3
16. My child has trouble remembering things.	0	1	2	3
17.. My child complains he/she never gets a fair share of things.	0	1	2	3
18. My child says people don't like him/her.	0	1	2	3
19. My child tends to be very selfish and self-centered.	0	1	2	3
20. My child is very shy.	0	1	2	3
21. My child is sensitive and has his/her feelings hurt easily.	0	1	2	3

	Never	Sometimes	Often	Always
22. My child avoids competition.	0	1	2	3
23. My child is a poor sport and a poor loser.	0	1	2	3
24. My child has trouble making friends.	0	1	2	3
25. My child seems to have little self-confidence.	0	1	2	3
26. My child cannot get along with my husband/wife.	0	1	2	3
27. There is a lot of arguing and fighting in our house.	0	1	2	3
28. My child expresses concerns about something terrible or horrible happening to family members or himself/herself.	0	1	2	3
29. My child expresses strong dislike for home and family.	0	1	2	3
30. One (or more) of my children has problems, also.	0	1	2	3
31. My child says strange things or asks unusual questions.	0	1	2	3
32. My child does strange things.	0	1	2	3
33. My child often has small accidents or injuries.	0	1	2	3
34. My child is a discipline problem at home.	0	1	2	3
35. My child is a discipline problem at school.	0	1	2	3
36. My child tells tall tales or lies.	0	1	2	3
37. My child often throws temper tantrums.	0	1	2	3
38. My child has attempted to seriously harm a person or animal.	0	1	2	3
39. My child manipulates situations to his/her own benefit.	0	1	2	3
40. My child does sexual things he/she shouldn't.	0	1	2	3
41. My child seems to welcome punishment.	0	1	2	3
42. My child disturbs other children by teasing, provoking fights, and interrupting others.	0	1	2	3
43. My child steals things.	0	1	2	3

	Never	Sometimes	Often	Always
44. I have to spank my child.	0	1	2	3
45. My child voices an intense dislike of school.	0	1	2	3
46. My child does not seem to be learning as he/she should.	0	1	2	3
47. The teachers complain about my child.	0	1	2	3
48. My child stares blankly into space and is unaware of his/her surroundings when doing so.	0	1	2	3
49. My child often complains of illnesses such as nausea, stomach pain or headaches.	0	1	2	3

Please circle YES or NO to the following statements as it pertains to your child.

50. My child's bowels move regularly.	YES	NO
51. My child is overweight or underweight. (underline which one applies)	YES	NO
52. My child is in a special program at school.	YES	NO
53..My child may have a learning disability.	YES	NO
54 .My child has a visual, hearing, or speech problem.	YES	NO
55. My child has a chronic illness or handicap.	YES	NO

I understand that if I am being seen in the context of marriage or family counseling that my medical note will have information about multiple parties contained in it. If in the event that a couple or family members become involved in legal matters against one another, none of the parties involved in counseling can have copies of the record without all parties giving written consent.

I understand that the therapists at Paraclete Counseling Center do not have training in forensic psychology, and therefore are not qualified to offer opinions for legal testimony. I agree that I will not ask my therapist to provide any legal affidavit. Furthermore, I agree not to subpoena my therapist for legal testimony. By signing below, you are agreeing to abide by this policy.

_____ _____

Signature Date

_____ _____

Signature Date

Paraclete
Counseling Center, Inc.

3905 Johns Creek Court, Suite 260, Suwanee, GA 30024
(770) 753-0350 office (770) 497-9536 fax

INFORMED CONSENT AND AUTHORIZATION

Paraclete Counseling Center, Inc. offers biblically sound, psychologically competent professional counseling for individuals, couples, families and groups. Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order for us to work most effectively together, I ask that you carefully read the information below. If you have any questions regarding the following information, please discuss these with me during your first session.

All counselors operate from some particular moral basis, which may or may not come from a religious perspective. We want to inform you that all the counselors in this office operate from a Judeo-Christian point of view. If you do not wish that to be included as a part of your counseling, please let me know during your first session.

All of our counselors have a minimum of a Master's degree in counseling, marriage & family therapy or other related field. The counselors in this office all have a license in the state of Georgia. We abide by the ethical guidelines of the ACA, AMHCA and the AACC.

BENEFITS AND RISKS OF THERAPY:

There are some risks as well as many benefits with therapy. For example, in therapy, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. Sometimes a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives.

While you consider these risks, you should know also that scientists in hundreds of well-designed research studies have shown the benefits of therapy. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved. Please note that there are no guarantees that you will get better as a result of participating in therapy. I encourage you to be an active participant in your therapy and collaborate with me to create and achieve your goals. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you.

When you enter into counseling, you are forming a therapeutic professional relationship with me that is different than other social relationships you have. There may be times in which you may see me in social settings other than the therapy setting. In other such settings you may experience a dual relationship with me. A dual relationship refers to any situation where multiple roles exist between a therapist and a client. If you see me in another social situation, I will only interact and speak with you if you first initiate contact with me. If you do not initiate contact with me, then I will not initiate any conversation with you.

If you have a dispute or complaint with me as your therapist, I encourage you to come to me first to discuss the complaint. If we cannot resolve it, then I encourage you to discuss the issue with the center director to try to resolve the dispute.

CONFIDENTIALITY:

All information shared between counselor and client is confidential and privileged and will not be revealed unless required by law in such cases of suspected child abuse or threats of physical harm to self or others.

There are two situations in which I might talk about your case with another therapist. When I am out of the office or am not "on call", another therapist in this office will be available to you in emergencies. Therefore, this therapist needs to know about you. Generally, I will tell this therapist only what he or she needs to know about you to help you in an emergency. Second, in order to give high quality treatment, I sometimes consult with other professionals about my clients. The same rules and laws that I am bound by also bind these professionals in order to protect your confidentiality.

In the course of treatment, it is necessary for me to contact you. Please check which forms of communication we may use (one of these must be a phone number):

□ Phone numbers _____
_____ Initial here if it is okay to leave message

□ Email _____

Sometimes it will be necessary for me to contact you or a family member in the case of life and death situations. In these situations, I ask you to provide me with the name and number of a contact person so I may contact them in certain life or death situations. Name of contact person _____ Phone number _____
By initialing here_____ you give me permission to contact this person only in the event of a life or death emergency.

In non-emergency situations, please leave me a message on my confidential voicemail by calling 770-753-0350. My extension is _____.

PAYMENTS AND BILLING:

Therapy Sessions: Most therapy sessions last 50 minutes. If you require a longer or shorter session, it will be prorated based on your fee. Any client who has a balance of fees for more than two sessions will be unable to continue therapy until your payment is made. Individual exceptions can be made through your individual therapist. If you are unable to pay these fees, please talk to me about this to make other arrangements. Please remember that final payment of your bill is your responsibility NOT your insurance company. In the event that we are unable to collect fees owed by you, we reserve the right to use an outside collection agency to work on our behalf to collect overdue balances.

Initial Session	$130
Family/Couples	$110
Individuals	$110
Addiction Assessment	$400

(Initial Session, Testing, Reports & Phone Interview with significant other)

Cancellation of Appointment: If you must cancel your appointment, please call the office and leave a message on my voicemail. **You must cancel at least 24 hours in advance of your scheduled appointment.** If you do not cancel your appointment **24 hours in advance**, you will be charged our standard fee, not your co-pay _____ (Initial here). Insurance does not cover late cancellations or no shows. Exceptions will be made in case of illness or other emergency. Your cooperation in this matter is greatly appreciated.

Telephone Consultations: I understand that at times telephone consultations are necessary. If a conversation lasts over 10 minutes, please see the fee breakdown below.

10-20 minutes	20-30 minutes	35-50 minutes
$30	$55	$110

Court/Legal Testimony: The counselors in this practice are not trained in forensic psychology, and therefore rarely give court testimony. If you believe that court testimony may be necessary, please discuss this with me in your first session. If you subpoena me to court and I must cancel my regular schedule to be available for court, you will be charged $1500 per day. If I have cleared my schedule for court, I need 48 hours notice for cancellation of court appearance or you will be charged $1500.

Reports: I will not charge you for my time spent making simple reports to your insurance company. However, any reports needed for other professionals, including but not limited to lawyers, courts, other medical doctors, and school officials, will be charged a fee, please see the fee breakdown below.

10-20 minutes	20-30 minutes	35-50 minutes
$30	$55	$110

Testing: At times I may find it necessary to have you complete an assessment to help better evaluate your situation. Some of these cases include but are not limited to depression, anxiety, marital therapy, addiction, etc. These assessments will be discussed with you prior to that time and fees will be discussed then. Assessments range in price from $40-110.

Unpaid Balances: If you have an unpaid balance, no records, test results or evaluations will be released until the balance is paid in full. _____ (Initial here)

Returned Checks: If your check is returned with Non Sufficient Funds, you will be assessed a $30 fee.

:

USE OF TECHNOLOGY IN THE THERAPY PROCESS

I understand that there are many forms of technology available to us for communication. Please know that I cannot guarantee the safety of cell phone conversation or texting. I also cannot guarantee the safety of email. Email through Paraclete Counseling Center is not encrypted. Therefore, I ask you to limit your email for the purposes of scheduling appointments. If you choose to send therapeutic content in an email, I cannot guarantee the confidentiality of this information. Please know that copies of texts or email will be printed and put in your file. The policy of Paraclete Counseling Center is that therapists are not allowed to be a "friend" on Facebook with clients. We have a business Facebook page, so you can "like" the Paraclete Counseling Facebook page. If you choose to "like" our page, please know that others might assume you have some professional relationship with us.

TERMINATION:

The best way of terminating therapy is to complete a plan with me that brings the therapy process to a close. The professional therapeutic relationship between you and me will be considered terminated if there has been no face to face psychotherapy for a period of 90 days _____ (Initial here). It is our standard office procedure to send a letter documenting termination to the address provided in your intake information.

IN CASE OF EMERGENCY:

In the event you have a life-threatening emergency, please call 911 or go to your nearest emergency room or call GA Crisis & Access Line @ 1-800-715-4225.

I have read and understand the conditions and information above and give authorization to begin treatment.

_____ _____
Signature of client or parent Date

_____ _____
Signature of therapist Date

IMPORTANT EXTENSIONS:

New Clients	Option 2		
Lisa Poore/Director	102	Kami Legg	109
Heather Cobb	103	April Miller	101 or 0
Troy Snyder	104	Directions to Office	Option 4
Pat Caffrey	105	Office Address/Fax#	Option5
Sanona Williams	106		
Danielle Olowoyo	107		
Sylvain Panu	108		

A copy of this form will be kept in your confidential file. If you wish to have a copy for your records, please request one.
Rev. 9/16