Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services
5855 Jimmy Carter Blvd., Suite 200, Norcross, GA, 30071
Office: (404) 630-1361 / Fax: (770) 441-9177

ADOLESCENTS INTAKE FORM (13-17 years-old)

I- DEMOGRAPHIC INFORMATION

Child's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Where was your child born? _____

Residential Address:_____ City: _____ Zip Code: _____

Parents phone: _____ Child's phone:_____ Can we leave a message? Yes [ ] No [ ]

Parents (or legal guardian's information):

Father: _____Age _____ Phone: _____

Address: _____ Place of Birth: _____

Mother: _____ Age _____Phone: _____

Address: _____ Place of Birth: _____

If parents are separated, how long have you been separated or divorced? _____

How long have you been living in Georgia?_____ How long in the United States?_____

Has lived in other states? Yes [ ] No [ ] Which? _____

Referred by: _____ Phone: _____

Reporting Person: _____ Relationship to Patient : [ ] Mother [ ] Father [ ] Other: _____

Contact person in case of emergency:

Name: _____ Telephone #: _____

We will only contact this person if we believe it is a life or death emergency. Please indicate that we may do so: Yes [ ] No [ ]

Who does your child live with? [ ] Father [ ] Mother [ ] Both parents
[ ] A family member (who) _____ Other person (who) _____

Who has the child's legal custody?

[ ] Both parents [ ] Mother [ ] Father [ ] DFCS [ ] Other _____

List information of your other children and brothers/sisters of your child and other people living at home:

Name	***Relationship***	***Age***
1.		
2.		
3.		
4.		
5.		
6.		
7.		

II- REASONS TO LOOK FOR COUNSELING

What problem motivated you to seek help for your child?

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III- DEVELOPMENTAL HISTORY

Pregnancy, Birth, and Childhood:

Please indicate any special circumstances or problems during pregnancy or delivery and childhood of your child:

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IV- CURRENT SYMPTOMS OR BEHAVIORS CHECKLIST

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

Mark only those that apply to your child or yourself if you are the client.

[ ]Insomnia	[ ]Cruelty to animals	[ ]HIV +
[ ]Loneliness	[ ]Problems with authority figures	[ ]High expectations from parents
[ ]Isolation	[ ]Run away	[ ]Don't have money
[ ]Sadness	[ ]Live in a bad neighborhood	[ ]Sexual problems
[ ]Lack of energy	[ ]Dizziness	[ ]Loosing my friends
[ ]Loss of appetite	[ ]Headaches	[ ]Worried about becoming pregnant
[ ]Crying for no reason	[ ]Shaking	[ ]I am pregnant
[ ]Low self-esteem	[ ]Memory loss	[ ]Don't know anything about sex
[ ]Anxiety	[ ]Memory problems	[ ]Peer pressure to have sex
[ ]Nervousness	[ ]Fatigue	[ ]Poor grades
[ ]Panic attacks	[ ]Tired	[ ]Problems with my teachers
[ ]Fears	[ ]Eating desorders	[ ]No Friends at school
[ ]Perfectionism	[ ]Sexually transmitted disease	[ ]I do not understand my school subjects
[ ]Shyness	[ ]Feel overweight	[ ]Hanging out with gangs
[ ]Worrying too much	[ ]Too skinny	[ ]Pressure to join a gang
[ ]Feelings of guilt	[ ]Purging alter eating too much.	[ ]Fighting at school
[ ]Get distracted	[ ]Terminal illness	[ ]Problems with parents
[ ]Hyperactivity	[ ]Unable to relax	[ ]Parents are too strict
[ ]Concentration problems	[ ]Compulsive behaviors	[ ]My parents have problems
[ ]Impulsivity	[ ]Obsessive thoughts	[ ]Parents getting divorced
[ ]Sudden temper changes	[ ]Auditory hallucinations	[ ]Sexual abuse at home
[ ]Anger	[ ]Ideas of self-harm	[ ]Physical abuse at home
[ ]Loss of control	[ ]Use of alcohol	[ ]Other (specify)
[ ]Aggressive	[ ]Use of drugs	
[ ]Violent	[ ]Smoke cigarettes	

V- EDUCATIONAL HISTORY

Name of current school _____ Grade _____

Has your child ever repeated a grade? [ ] Yes [ ] No Which Grade?: _____

Has your child been in special education? [ ] Yes [ ] No

Failing or low grades in the following subjects? _____

_____

Behavioral Problems at School. Has he/she been expelled or suspended from school? _____

_____

_____

VI- MEDICAL HISTORY

Medical problems and medication your child takes_____

_____

Has your child been hospitalized for medical problems? [ ] Yes [ ] No Explain the reasons _____

_____

Mental Health

Has your child ever received mental health treatment? [ ] Yes [ ] No

Please list any previous therapy/counseling received. _____

_____

Has your child tried committing suicide or engaged in self-harm? [ ] Yes [ ] No

When was the last time? _____ What method did your child use?_____

Did your child think about hurting another person? _____

Has your child been abused physically or sexually? [ ] Yes [ ] No

If your response is YES, please respond to the following questions:

Who is/ was abusing him / her? _____ When did it happen? _____

Did anybody report it to DFCS or the Police? [ ] Yes [ ] No Who reported it? _____

It has been miltreated with physical or psychological violence? [ ] Yes [ ] No

If your response is YES, please respond to the following questions

Who has miltreated him / her? _____ When did it happen? _____

Did anybody report it to DFCS or the Police? [ ] Yes [ ] No Who did it? _____

VII- SUBSTANCE USE HISTORY

[ ] My child does not use drugs. Please continue with next section

[ ] My child uses alcohol or drugs.

If the answer is affirmative, please respond to the following questions related to alcohol or drugs abuse.

Minor's substance use history

_____

_____

Any past treatment for substance abuse? [ ] Yes [ ] No

If YES, please explain:

_____

_____

VIII- CURRENT & PAST LEGAL HISTORY

Has your child had any legal problems or ever been arrested? [ ] Yes [ ] No

If your response is affirmative, please explain. If your response is NO, please go to the next Section.

_____

_____

IX –EMPLOYMENT HISTORY

Note: Adolescents or children that are not employed and who are currently in school, do not have to answer these questions. If your child is working part time, please respond these questions. **If your child is a student and is unemployed, go to the next section.**

Did he/she work? [ ] Yes [ ] No Where? _____ How many hours? _____

Where does your child work? Position? _____

Additional Information:

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Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services

INFORMED CONSENT FOR COUNSELING SERVICES WITH ADOLESCENTS

Welcome to the Counseling Institute of Atlanta, Inc, for Counseling Services. Thank you for trusting us to assist you and your child with your concerns. It is our desire to help you in this moment of your life. We are honored that you have chosen us as your therapist. We will do everything we can to help you move forward and solve your problems.

Please take the time to complete this form, make sure you read and understand this document. If you have any questions, do not hesitate to ask your therapist.

LIMITATIONS OF SERVICES: I understand that the Counseling Institute of Atlanta, Inc.'s services are limited to counseling services including assessment, consultation, therapy, and intervention. I understand that assessment services may include the use of questionnaires or tests and intervention services may include counseling and psychotherapy. I understand that my therapist is not warranting a cure or offering any guarantee of results or improvement of any condition

ASSUMPTION OF RISKS: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. Your active participation and commitment are important during this process. Some people may need a few sessions and others may need more. Come to our office on time according to your scheduled appointment. If for any reason, you are not able to attend, please let us know in advance so we can use that time with another client.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

I understand that the potential benefits of undergoing counseling services may include obtaining professional opinion and an increased understanding of myself. I understand that potential risks may include limited predictive validity of mental health assessment procedures, possible disagreement with the opinions offered to me, and possible emotional distress concerning my situation.

LIMITS OF CONFIDENTIALITY: I understand that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information or under certain other conditions listed below. I understand that confidential and privileged information may be released without my consent or authorization for the following purposes: (1) to provide needed professional services to the patient or the individual or organizational client, (2) to obtain appropriate professional consultations, (3) to protect the patient or client or others from harm (4) to obtain payment for services, in which instance the disclosure is limited to the minimum that is necessary to achieve the purpose. I hold the provider harmless for releasing information under any of the above conditions.

To release information about your therapy, I need to have written releases from you and your parents or legal guardian. In general, the law protects the confidentiality of all communications between clients and counselor. I only release information about our work with your written releases. Clients often give me releases to talk to their individual therapists, and/or previous therapists. This helps me to coordinate your therapy so that it will be most helpful to you.

There are also a few situations in which I am legally required to protect someone, even if that involves revealing some information about a client's treatment. 1. If I believe that a child, an elderly person or a disabled person is being abused, I may be required by law to file a report with the appropriate state agency. 2. If I believe that a client of mine is threatening serious bodily harm to another person, I may be required to take protective action, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. 3. If a client of mine threatens to harm him/herself, I may be required to seek hospitalization for that client, or contact family members or others who can help provide protection.

Occasionally, I find it helpful to consult with other professionals about a situation in therapy. In these consultations, I avoid revealing the identity of my clients. I will usually inform you of these consultations.

TERMINATION OF THERAPY: Each stage of therapy has important ramifications for the client's motivation, growth and self-esteem. Termination, although an ending of therapy, is a part of the development of the therapeutic relationship. A client who misses more than two sessions without notifying the therapist should be seen as initiating a premature termination. The staff from the Counseling Institute of Atlanta, Inc., will try to contact you, but your case will be terminated/closed if we do not hear back from you. If you are feeling better or planning not to return to therapy, it is important that you come in for a final session, so that we can discuss the reasons leading to the decision, the course of therapy and any relevant referrals. A case is considered terminated when there is no longer any regular sustained contact following a specified treatment plan.

STATEMENT OF UNDERSTANDING: I understand the above information and/or have discussed any questions related to the above information to my satisfaction. By signing this agreement, I agree to the terms and conditions outlined herein and have had the opportunity to ask questions and/or discuss concerns.

PAYMENT: Our fees are based on a therapeutic hour of 50 minutes for psychotherapy services. We accept cash, or credit/debit cards. If you fail to cancel your appointment within two days in advance, you will be charged the full session amount. You will have to pay that session at the beginning of your next appointment or call us to provide your card information. We will try to contact you two days in advance to remind your appointment, but it is your responsibility to cancel or reschedule the appointment on time.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure or confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with your therapist.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. We realize that many people prefer to text and/or email because it is a quick way to convey information. However, please know that it is our policy to utilize these means of communication strictly for appointment confirmations (nothing that could be inferred as therapy). Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that your therapist will not respond. You also need to know that we are required to keep a summary or a copy of all emails and texts as part of your clinical record that address anything related to therapy.

Facebook or Social Media It is our policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Instagram, etc. because it may compromise your confidentiality. The Counseling Institute of Atlanta has a business Facebook page and LinkedIn. You are welcome to follow us on any of these pages. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to The Counseling Institute of Atlanta. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

Google, Bing, etc.: It is our policy not to search for our clients on Google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself to your therapist as you feel appropriate. If there is content on the Internet that you would like to share with your therapist for therapeutic reasons, please print this material and bring it to your session.

Faxing Medical Records: If you authorize us (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, we may need to fax that information to the authorized entity. It is our responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of our fax machine. However, our fax machine is kept behind two locks in our office. And, when our fax machine needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

Recommendations to Websites or Applications (Apps): During the course of treatment, your therapist may recommend that you visit certain websites for pertinent information or self-help. She or he may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to your therapist if you would like this information as adjunct to your treatment or if you prefer that your therapist does not make these recommendations.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

In Case of an Emergency

The Counseling Institute of Atlanta is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225

- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911
- Go to the emergency room of your choice

Informed Consent for special Circumstances
Adolescents 16 - 18 years old and some College Students

At these ages in the State of Georgia, confidentiality as a privilege belongs to the client. I am aware that in most cases, children may still be legally dependent, living at home, and that parents are likely paying for therapy; nonetheless, this is the law. Therefore, I must have the written consent of the client to communicate with parents regarding issues related to their treatment.
It is my philosophy to facilitate communication between adolescents and their families and I will attempt to bring parents' concerns into the therapy. When I deem it clinically important, periodic family meetings will be requested.
If an adolescent client is engaged in risk taking or potentially dangerous behaviors, I operate under the same principles that apply to adult clients, working toward therapeutic remediation of the behavior(s) in question. The dangerousness of the behavior(s) is a point of clinical judgment and in circumstances in which an adolescent refuses to cooperate with treatment recommendations to correct the behavior, it may be necessary to breach confidentiality for their protection and in rare occasions terminate treatment.
Information received from parents via phone calls, voice mail, and/or any written communication will not generally be kept secret as this impedes the therapeutic process and relationship.
I understand the above information and/or have discussed any questions related to the above information to my satisfaction.

Our Agreement to Enter into a Therapeutic Relationship

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.

By signing this agreement, I agree to the terms and conditions outlined herein and have had the opportunity to ask questions and/or discuss concerns.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist, and you are authorizing your therapist to begin treatment with you.

_____ _____ _____

Client Name (Please Print) **Client Signature** **Date**

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) Date

_____

Parent's or Legal Guardian's Signature

The signature of the therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services

NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT

My signature acknowledges that I was informed and I have received a copy from the Counseling Institute of Atlanta, Inc. of the Notice of Policies and Practices to Protect the Privacy of Your Health Information. This notice details the policies that protect the privacy of my personal health information.
I consent to the use and disclosure of my protected mental health information by the Counseling Institute of Atlanta, Inc. for the purpose of providing treatment to me, obtaining payment for the mental health services provided, and/or to conduct other counseling services.
I understand that I may ask questions and discuss any concerns that I might have regarding these policies and practices with the staff of the Counseling Institute of Atlanta, Inc.

Signature of Client _____ Date_____

Client's printed name _____Date of Birth _____

Signature of Parents/legal guardian _____ Date _____

Parent's printed name _____ Date of Birth _____

Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services

Authorizations

Verification of Information

My signature means that I am providing the information related to my case / my child's name. I affirm that all the information that I have provided and that the evaluator has obtained is true and correct. I am the only one responsible for providing the information contained in this clinical history.

Confidentiality

This is a strictly confidential patient/ examinee or client psychological record. Redisclosure or transfer without the client's or examinee written consent is strictly prohibited, except as permitted by the law.
The client understands that secure and private communication cannot be completely guaranteed through cellphones and e-mail. It is the decision of the client to communicate, or not, through these "non-secure" technologies. If the client uses these "non-secure" technologies to contact the counselor, the counselor will communicate with the client through these "non-secure" technologies as well, until the client indicates otherwise. Please, indicate what type of communication is allowed:

Communication via phone or cell phone _____ Communication via voice message _____
Communication via fax _____ Communication via e-mail _____
Communication via text message _____ Communication via teleconference _____

Authorization for release of information

If my case or my child's case is of a legal nature, I authorize the release of information related to my case to my probation and parole officer, my attorney or legal counsel, the court and its agents, DFCS, or any other agency or entity legitimately related to my case. I will be informed by my therapist in case of any request for information.

_____ _____
Client's signature Date

_____ _____
Signature of Parents/legal guardian Date

Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services

CANCELLATION AND MISSED APPOINTMENT POLICIES

Our fees are based on a 50-minute session for psychotherapy services. We accept cash or credit / debit cards. If you do not cancel your appointment within two days in advance, you will be charged the full fee for the session. The responsible parent or guardian will have to pay for that session at the start of their next appointment or call us to provide their card information; Note that we will try to contact you two days earlier to remind you of your appointment, but it is your responsibility to cancel or reschedule the appointment in time.

Thank you for your understanding and cooperation.

My signature below accepts that I understand and accept the terms and conditions of this rule.

_____ _____
Client's signature Date

_____ _____
Signature of Parents/legal guardian Date