ADOLESCENT INTAKE FORM (ages 12-17)

*Adolescent please fill out pages 1-3 (**OPTIONAL**), parent/guardian please fill out pages 4-8*

CLIENT INFORMATION

Name:_____ Date of Birth: _____

Age: _____ Phone (Cell): _____

School: _____ Grade: _____

Please share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) that you use:

_____

Do your parents have access to your electronic communication? (Y/N) _____

Do they have any issues with your use of phone, text, electronic communication? (Y/N) _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful at when you try?

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for? _____

_____

What would you like to see happen as a result of counseling? _____

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? Yes No If yes, what did you find most helpful in therapy?

_____

If yes, what did you find least helpful in therapy? _____

_____

SUBSTANCE USE AND HISTORY

Do you currently use alcohol? If yes, how often do you drink? If yes, how much do you drink?

_____

Do you currently use tobacco? If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? If yes, what drugs do you use? If yes, how often do you use?

_____

FAMILY HISTORY

Are your parents married or divorced? _____

Do you think their relationship is good? Y N Unsure

If your parents are divorced, whom do you primarily live with? _____

How often do you see each parent? Mom_____% Dad _____%.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

_____

PEER RELATIONS

How do you consider yourself socially: ___outgoing ____shy ____depends on the situation.

Are you happy with the amount of friends you have? Y N

Have you ever been bullied? Y N

Are your parents happy with your friends? Y N

Are you involved in any organized social activities (e.g. sports, scouts, music)?

_____

SCHOOL HISTORY

Do you like school? Y N

Do you attend regularly? Y N

What are your current grades? _____

Do you feel you are doing the best you can at School? Y N

EATING BEHAVIOR & BODY IMAGE

What is your relationship like with food? Do you have concerns about your eating patterns/behaviors?

_____

_____

Does your weight/shape/appearance affect the way you feel about yourself?

_____

_____

What is your relationship like with your body?

_____

What is your relationship like with exercise?

_____

Is there anything else that you'd like to share with me?

_____

_____

_____

CHILD/ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name:_____ Date of Birth: _____

Age: _____ Gender:_____ Race/Ethnic Origin: _____

CURRENT REASON FOR SEEKING COUNSELING FOR YOUR CHILD

Briefly describe why you have brought your child to counseling at this time?

_____

_____

What would you like to see happen as a result of counseling?

_____

What is most concerning right now?

_____

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe: _____

Did your child have health problems at birth? Yes _____ No _____ If yes, describe:

_____

Did your child experience any developmental delays (e.g. walking, talking)? Yes ___ No ___

If yes, describe: _____

Has your child experienced emotional, physical, or sexual abuse? Yes ____ No ____ Not sure _____ If yes, describe: _____

COUNSELING HISTORY

Has your child previously seen a counselor? If Yes, who, when, and for what reason?

_____

_____

What did you find most helpful about your child's therapy? Least helpful?

_____

_____

Has your child taken medication for a mental health concern? Yes_____ No _____

If yes, please list medications and dosages: _____

Does your child have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe: _____

SUBSTANCE USE & EATING BEHAVIOR

Do you have any concerns with your child's use of alcohol or drugs? (Y/N) _____

If yes, please explain your concern:

_____

Do you have concerns about your child's eating behavior? Weight? Body size/shape? If yes, please explain:

_____

What is your relationship like with food and your body?

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns about your child using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____

If yes, please explain your concern: _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, child, at present, or have had a significant effect upon you or your child in the past.

_____

FAMILY HISTORY

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

_____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

PARENT'S MARITAL STATUS

(this question refers to the biological parents relationship)

__ Single ___ Married (legally) ___ Divorced ___ Cohabitating ___ Divorce in process ___ Separated ___ Widowed ___Other

Length of marriage/relationship:_____

If divorced, how old was your child at time of divorce? _____

If divorced, How much time does your child spend with each parent? Mother_____%, Father _____%

YOUR CHILD'S STRENGTHS

What activities do you feel your child is successful at when they try?

_____

What positive qualities would you say your child has?

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your child's life? (Please describe)

_____

Is there anything else you would like to share?:

_____

_____

THERAPIST-CLIENT SERVICE AGREEMENT: ADOLESCENTS

WHAT TO EXPECT FROM THERAPY:

My goal is to provide a safe space where you can fully express yourself and feel comfortable being "you." You can expect that I will listen non-judgmentally, do my best to understand your concerns and your perspectives, and validate your experiences. You can also expect that what we discuss will be kept private.

THERE ARE A FEW EXCEPTIONS, AND HERE THEY ARE:

1. You tell me that you plan to hurt yourself or someone else;
2. You tell me that you are being abused physically, sexually, or emotionally, or that you have been abused in the past;
3. You tell me that you are or have engaged in a sexual relationship with someone who is significantly older than you. In most cases I would be required by law to report this to CPS.

WHAT TO EXPECT ABOUT MY COMMUNICATIONS WITH YOUR PARENTS/GUARDIANS:

Generally speaking, I will keep the specifics of what you share with me between us.

HERE'S THE FINE PRINT:

1. If you tell me that you are involved in risk-taking behavior that becomes serious, then I will need to use my professional judgment to decide whether I must inform your parent/guardian, or we will discuss how to share this with your parent(s) together.
2. Even though I am committed to keeping your information confidential, I may believe that it is important for your parent/guardian to know what is going on in your life. In these situations we will work together to find the best way to discuss these things with your parent(s).
3. When meeting with your parents I will discuss challenges and progress that you have made in counseling. I will talk about general themes rather than specifics. The purpose of meeting with your parent(s) is to support our work together and to facilitate improved family relationships.
4. Ultimately, we will discuss what information you want shared with your parents/guardian and what information you do not and we will find an appropriate compromise. Parents/guardians can be part of that discussion.

WHAT I EXPECT FROM YOU:

1. You agree to attend therapy sessions as scheduled and participate to the best of your ability.

This includes putting your phone away for the session!
2. You agree to share as honestly as you are able to about your life, your experiences, your thoughts, etc. Even if sharing honestly means saying, "I don't want to be here," I want to hear it.
3. You agree to talk with me if you have thoughts/feelings about harming yourself/someone else.

WHAT I EXPECT FROM YOUR PARENTS/GUARDIANS:

1. You agree to support your child's treatment by doing your best to arrange for regular attendance. This includes scheduling appointments in a timely manner and being on time for appointments.
2. You agree to make yourself available for parenting consultations and /or family meetings as requested by your child or his/her therapist.
3. You agree to be supportive of the counseling process. This does **NOT** include: seeking detailed information about individual therapy sessions, coming into sessions that have not been previously agreed upon, contacting therapist between sessions to vent about your child, etc.

HOURS

- I offer late morning, afternoon, and evening hours on 4-5 days per week. I also offer Saturday hours as needed.
- Hours are subject to change on occasion and you will be informed in advance if this occurs. You will also be informed in advance about vacations and time out of office.

PHONE CALLS/EMAILS

- Austin Psychotherapy Associates' main number is **(512) 231-0164.** The office number is answered by staff during business hours and by a recording after hours.
- After hours and on Fridays, Saturdays, and Sundays, an answering service will direct your call to me or the person covering for me.
- The answering service phone number is **(512) 404-9098** and is on our office recording.
- I can also be reached via e-mail at JLSprengleLPC@gmail.com.
    - However, it should be noted that e-mail is not confidential and I cannot guarantee the privacy of electronic communication.

HOWEVER, I am not always immediately available; thus, in the event of an emergency, **please call 911 or visit your nearest ER**. Additionally, in the event that I am ill, on vacation, or at a location where telephone access is unavailable, I will provide you with backup numbers of alternative counselors or therapists you may call.

CANCELLATIONS

- I ask that clients please provide me with at least 24 hours notice should they need to cancel and/or reschedule an appointment. A client is responsible for payment of the full charge of the session if the session is missed and/or canceled without appropriate notice.
- This policy does not apply to cancellations made due to illness, emergencies, and other understandable reasons.

BILLING

- All charges are the responsibility of the client/client's parent regardless of insurance coverage or rate of reimbursement. Payment can be made via check, cash, and/or via Stripe/credit card.

- *Initial evaluation* (between 50 and 90 minutes) = $165
- *Follow-up sessions* (50 minutes) = $150
- *Missed sessions or canceled sessions without 24-hr notice* = $150
- **Checks are to be made out to Jessica Sprengle.**

- I am not currently in-network with any insurance companies. I am considered an "out-of-network provider." I advise you to check your insurance benefits as early as possible. If you are struggling with this, we can call your insurance company together during session.
- If you have health insurance, your policy may include benefits for out-of-network providers, and provide reimbursement for our sessions. Regardless of what your insurance pays, you are ultimately responsible for the full amount of your sessions. Should your insurance company provide reimbursement, I can provide a specialized receipt (either per session or per month) for you to submit.
- I offer sliding scale and cost of sessions can be negotiated on a case-by-case basis.
- My primary concern is always the well-being of the client and maintaining the therapeutic relationship. It is my hope that payment and/or issues around payment never interfere with that! Please contact me as soon as possible if you have any concerns about payment or fees.

I work with a group of independent mental health professionals, under the name of Austin Psychotherapy Associates. This group is an association of independently practicing professionals who share certain expenses and administrative functions. While the members share a name and office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

Client Consent to Therapy

By signing below, I am agreeing that I have read these forms, have had sufficient time to be sure that I considered it carefully, have asked any questions that I have needed to, and have understood it.

_____ _____

Client signature **Date**

_____ _____

Parent's signature **Date**

_____

Jessica Sprengle, LPC

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PATIENT COPY

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_____ _____

Client signature **Date**

_____ _____

Parent's signature **Date**

_____

Jessica Sprengle, LPC

Authorization for Release/Exchange of Information

This form provides your therapist with written permission to communicate with other individuals regarding your treatment (e.g., previous therapist, current health care providers, parent).

I, _____, authorize _____

to release and/or exchange information about my case with the following parties:

Name/Relation: _____

Address: _____

Phone Number: _____

Information to be Released or Exchanged
(check all that apply)
_____ Intake and history
_____ Treatment Progress
_____ Diagnosis and Treatment Plan
_____ Discharge Summary
_____ Verbal Consultation
_____ Billing & Payment
_____ Other (specify)_____
_____ All of the Above

This release shall be valid until the termination of treatment or until withdrawn in writing by the client during the course of treatment.

Client Name & date:

_____
Client Signature:

_____
Parent Signature if under 18

NOTICE OF PRIVACY PRACTICES
(The following is a summary. The full text is located in our waiting room.)

We at Austin Psychotherapy Associates are committed to maintaining the confidentiality of your medical information. In most cases, your records will not be released without your written consent (which you can revoke). However, there are a few exceptions. We are permitted to disclose your medical information to other professionals involved in your treatment.

- We are permitted to use and disclose your medical information to your insurance company, if you choose to use them, or as required by worker's compensation law.
- We may disclose your medical information for public health concerns as mandated by federal or state government.
- We are required to report child abuse or neglect.
- We may release information if you are under the custody of law enforcement, or if ordered by the court.

You may request in writing that we restrict how your information is disclosed for treatment, payment or healthcare operations. Although we are not required to restrict this information, we will do so except in emergency situations.

It is our policy not to release information to family members or other individuals without your written consent. You have a right to access your health records with some limitations. (See restrictions in the full text.) You must submit your request in writing to the Privacy Officer.

Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or with the government. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You
We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact Gayle Harkrider, Privacy Officer, at:

4601 Spicewood Springs Rd
Building 4, Suite 200
Austin, TX 78759

PATIENT COPY

This notice is effective November 14, 2006.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.