CK Counseling, LLC Intake Form

Client Information

Name_______________________________________ Date______________

Name preferred to be called/Nickname:____

Address_____________________________________ City___________ State____ Zip_________

Age: __________ Birth date: _____________ Mental Health Diagnosis:_________________

Medication(s):_____________________________

Parent/Guardian Information

Parent/Guardian 1:Name __________________________________ age:__________

Occupation:_______________________ Highest level of education:_______________________

Phone: Home:_________________ Cell:__________________ Work:_________________

EMAIL address:____

Parent/Guardian 2: Name ___________________________________ age:________

Occupation:________________________ Highest level of education:_______________________

Phone: Home:_____________________ cell:_____________________ work:________________

E-MAIL Address: ____

Preferred method to be contacted (check) ____Home phone, ____cell phone, ____e-mail

May I leave a message on phone? YES NO

Siblings: Name_________________________ age:____________ full step half (circle)

Name__________________________ age:____________ full step half

Name__________________________ age_____________ full step half

Name__________________________ age:____________ full step half

Pets: ____Dog, how many?____ name(s)____

____Cat, how many?_____ name(s)____

____Other, type?________ name(s)____

Family Dynamics

Please check all that apply:

____Parents are married and living together

____Parents are divorced and living together

____Parents are divorced and living apart in same state

____Parents are divorced and living apart in different states

____Mother is remarried

____Father is remarried

____Child lives with mother full time

____Child lives with mother part time

____Child lives with father full time

____Child lives with father part time

____Child lives with grandparent(s):

____Child lives in foster care

____Child lives with one parent and grandparents

____Child lives with aunt/uncle

____Other living arrangements:

FAMILY MENTAL HEALTH HISTORY

Please check all that apply: Indicate relationship (ie, father, mother, sibling, grandparent)

___Depression:

___Bipolar disorder:

___Alcohol/drug addiction:

___Schizophrenia:

___Borderline Personality Disorder:

___Narcissistic Personality Disorder:

___Dissociative Identity Disorder:

___Enuresis/bedwetting:

___ADHD/ADD:

___Sexual abuse:

___Physical/mental abuse:

___Autism:

___Genetic disorder(s): Type?

___Epilepsy

___Phobia(s): type?

___Developmental delays:

___Hospital stay due to mental health issue

___Other:

5. Would you say your child developed faster, slower, or about the same rate as other children?___________________________

SOCIAL HISTORY

1. Check all that describe your child socially:
   _____Other children seek him/her out for play
   _____He/She seeks others for play
   _____He/She prefers to play alone
   _____lots of children like him/her, FEW dislike him/her
   _____lots of children like him/her, BUT lots of children dislike him/her
   _____other children ignore my child most of the time
   _____other children ignore my child some of the time
   _____my child fights a lot with other children
   _____my child play cooperatively with other children most of the time

_____my child has difficulty making friends   _____my child makes friends easily

2. How many friends does your child have at home?_________
3. How much time does your child spend playing with friends?___________
4. Does your child have a best friend? YES NO First Name?_________________
5. How does your child get along with nonparent adults? (check all that apply)
   ____friendly ____cooperative ____disobedient ____disrespectful ___ obedient
   ____better behaved than with parents ____adults like my child
   ____other(describe)_________________________
6. How does your child get along with siblings?
   ____Protective ____aggressive ____won't share ____wants to be babied
   ____jealous ____ignores them ____plays well, limited arguing
   ____ plays well, but argues frequently ____always breaking up fights/arguments

7. Is your child sexually active? YES NO If yes, at what age?
8. Has your child ever been arrested, accused, or convicted of a crime? Please describe:

ACADEMIC HISTORY

1. Has your child attended day care? YES NO what age?

2. Age your child started Kindergarten?_____ Has your child repeated a grade? YES NO Describe:

3. Does your child have a learning disability? YES NO Please indicate type and when diagnosed:

4. Does your child have an IEP? YES NO Please indicate type and when it was introduced:

5. What school subject(s) does your child enjoy and thrive in?

6. What school subject(s) does your child dislike and struggle with?

7. How would your child's teacher(s) describe him/her?

___Shy   ___Overachiever

___Class clown ___Trouble maker

___Popular ___Other:___________

MAJOR CONCERNS/ STRESSORS

Please describe your concerns regarding your child/reason for psychotherapy:

How does your child *usually* cope when under stress? Check all that apply

____tries to solve problem alone ____seeks information regarding problem

____asks parents or other adult for help ____asks friends for help

____gives up easily ____makes a joke about the problem ____preys or asks God for help

____refuses to talk about it "holds it in" ____ignores or pretends there is no problem

____becomes anxious and/or tearful ____becomes angry and/or throws tantrums

____takes positive attitude toward problem ____get physically ill ____pretends to be ill

____becomes manipulative or deceitful ____withdraws, tries to be alone

____other:

All information is correct to the best of my knowledge.

_________________________________ Date _______________
Parent/Guardian Signature

_________________________________ Date_________________
Parent/Guardian Signature

Disclosure Statement

Christa Kay Clarke, MA, LPC, NCC, RPT
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Greenwood Village, CO 80111
303-669-9698
christa@playtherapy4kids.com

My degree is a Master of Arts in Counseling; Certified Child & Adolescent Therapist, Licensed Professional and National Certified Counselor. I have training and experience in child and adolescent and adult mental health issues, including but not limited to; ADHD, Adoption, Depression, Grief/Loss, Mood Disorders, Parenting, and Trauma.
I am a member of the American Counseling Association and The Association for Play Therapy.

REGULATION OF PSYCHOTHERAPISTS

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical social worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctorial supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified.

4. **CLIENT RIGHTS AND IMPORTANT INFORMATION**

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy. Please ask if you would like to receive this information. My fee is $120 per hour for counseling.

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies.

d. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.

e. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

5. DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

I have read the preceding information and understand my rights as a client/patient. I also acknowledge that I have received a copy of this Disclosure Statement.

__________________________________ _________________________

Client Signature/Legal Representative Date

__________________________________ _________________________

Therapist Date

Informed Consent

CK Counseling, Christa Kay Clarke, MA, LPC, NCC, RPT in compliance with national standards of ethics, is required to disclose all billing and financial matters regarding psychotherapy services. As a client of CK Counseling, you understand:

1. My usual and customary rate for providing direct face-to-face psychotherapy services is $120 per 50 minutes. Family & Parenting rates are $145 per 50 minutes. Consultation rate $50 per 30 min.
2. You will be billed $120 for not giving a minimum of 24 hours notification of cancellation. This outstanding balance must be paid prior to additional psychotherapy services being delivered. I, Christa Kay Clarke, reserve the right to wave this fee in certain circumstances.
3. I accept limited insurance; please check with your insurance company to verify coverage. I will provide a "super bill" at the end of every 4 sessions that can be filed with your insurance as an out-of-network provider if I am not a provider with your insurance company.
4. You will be billed for non-routine services such as extended telephone consultations, crisis intervention, report writing, extended care coordination with other providers at a rate of $15 per 15 minutes. You will be informed of events involving additional billing prior to the event.
5. Any legal reporting, consultation, or coordination will be billed at a rate or $30 per 15 minutes.
6. I, Christa Kay Clarke, reserve the right to pro-rate my services on a case-by-case basis.

A credit card is only billed for outstanding balances and for "no show" appointments. You agree that your credit card can be billed if such circumstances arise.

Credit Card #____ Exp. Date_________________

CVV#________

Please discuss any questions or concerns you may have regarding the financial arrangements concerning your psychotherapy services.

I have read and understand the fees of CK Counseling.

____ ________________

Client/Parent/Guardian Signature Date