Child Intake Form

Name:_____ **Date:**_____

Date of Birth:_____ **Social Security Number (SSN):**_____

Address:_____

_____

Phone:_____

Email:_____

Ok to leave message? Phone: yes no **Text:** yes no **Email:** yes no

Primary Insurance Company:_____

Plan Name:_____

Policyholder's Name:_____

Policyholder's Date of Birth:_____

Policyholder's ID Number:_____

Policyholder's Group Number:_____

Policyholder's Employer:_____

Insured's Policy or ID Number:_____

Insured's Group Number: _____

Deductible/Co-pay/Coinsurance:$**\_\_\_\_\_ **$_____ **%**_____

Insurance Billing Address:_____

_____

Insurance Phone:_____

_____

Malia Parecki, LCSW, CMHS

4605 NE Fremont Ave Portland #210E

(503)310-6845 ● www.**pareckicounseling.com**● pareckicounseling@gmail.com

Secondary Insurance:_____

Policy or ID Number:_____ **Group Number:** _____

Co-pay:_____

Secondary Insurance Billing Address:_____

_____

Secondary Insurance Phone:_____

Insurance companies vary in the confidential information they require in order to pay for services. In addition to information regarding diagnosis and dates of service, some insurance providers will request treatment plans, progress reports, or session notes.

Your signature below indicates that you have read and understood all of the above material and consent to have Malia Parecki, LCSW, CMHS release your confidential information as needed to collect payment from your insurance.

_____

Client Signature Date

Primary Care Provider's name:_____**Phone:**_____

When was your last check-up?_____

Please list all medications and over the counter medications and/or supplements your child currently takes:

Medication/Supplement:	**Dose**	**Prescribed/recommended by:**

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Mental Health Questionnaire

Name of child: _____ Date of Birth:_____ Age: _____

Name of person completing this form: _____ Date: _____

Relationship to child: _____

In an effort to be as helpful as possible to you, it is important that I understand your concerns as well as your goals for counseling. Please answer the following questions as completely as possible.

1. What is the problem for which you seek solutions?

2. What attempts have you made to solve the problem that brings you in today?

3 What changes have you noticed as a result of the above-mentioned attempts?

4. What needs to happen in our initial session that would be most helpful to you?

5. Are there any religious, spiritual and/or cultural issues that are important to your child/family?
☐ Yes ☐ No If yes, please explain:

Family Information

6. Immediate family information:

Parents/Siblings Names	*Relationship to Child*	*Dates of Birth*	*Living at Home?*
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

7. Please list any significant others involved with your child:

Name	*Relationship*

8. Who is your support system? What people are important to you and to whom you can turn for help when you need it?

School History

9: School: _____

10: Has your child:

Yes	***No***	
☐	☐	Received Special Education services?
☐	☐	Been suspended/expelled? (*If yes, please circle appropriate choice)*
☐	☐	Received academic honors?
☐	☐	Attended multiple schools?
☐	☐	Been afraid to attend school?
☐	☐	Had other difficulties in school? *If yes, please explain:* _____

_____

Trauma History

11. Has your child ever experienced or witnessed:

Yes	***No***	***Don't know***		***Yes***	***No***	***Don't know***	
☐	☐	☐	Homelessness	☐	☐	☐	Out-of-home placements
☐	☐	☐	Domestic violence	☐	☐	☐	Sexual abuse
☐	☐	☐	Violence in the community	☐	☐	☐	Physical abuse
☐	☐	☐	Significant loss through divorce or death				

Legal History

12. Has your child had problems with:

Yes	***No***		***Yes***	***No***	
☐	☐	Running away	☐	☐	Vandalism
☐	☐	Stealing	☐	☐	Gang interest/involvement
☐	☐	Fire setting	☐	☐	Being cruel to animals

13. Is your child currently:

Yes	***No***		***Yes***	***No***	
☐	☐	Assaultive	☐	☐	On a Diversion Contract
☐	☐	Sexually acting out	☐	☐	On probation/parole

Substance Abuse History

14. Does your child:

Yes	*No*	*Don't know*		*Yes*	*No*	*Don't know*	
☐	☐	☐	Use any drugs	☐	☐	☐	"Huff" inhalants
☐	☐	☐	Drink/abuse alcohol	☐	☐	☐	Smoke cigarettes
☐	☐	☐	Abuse over-the-counter or prescription drugs				

15. If yes, has he/she received any treatment for this problem?
☐ Yes ☐ No ☐ Don' know

16. Has anyone else in the family had a problem with drug or alcohol abuse?
☐ Yes ☐ No *If yes, please explain:* _____

_____

17. Do you want/need a referral for drug/alcohol services? ☐ Yes ☐ No

Mental Health History

18. Has your child had any counseling in the past?
☐ Yes ☐ No ☐ Don' know
If yes, where? _____

19. How long did your child receive these services? _____

20. How helpful were these services?
☐ Not helpful at all ☐ Somewhat helpful
☐ Helpful ☐ Very helpful

21. Has anyone else in your family:

Yes	*No*	
☐	☐	Received counseling?
☐	☐	Been hospitalized for psychological/psychiatric reasons?

If yes, who? _____

Safety Issues

22. Has your child ever:

Yes	*No*	*Don't know*	
☐	☐	☐	Tried to seriously harm him/herself
☐	☐	☐	Made statements about wanting to die
☐	☐	☐	Attempted suicide
☐	☐	☐	Threatened to harm others
☐	☐	☐	Purposefully hurt another

IF yes to any of the above, please explain? _____

_____

23. Does your child have access to:

Yes	*No*	*Don't know*	
☐	☐	☐	Guns
☐	☐	☐	Ammunition
☐	☐	☐	Knives/other weapons
☐	☐	☐	Explosives
☐	☐	☐	The Internet
☐	☐	☐	Do you have guns/weapons in your home?
☐	☐	☐	Do you have ammunition in your home?

24. In general, please describe your child's mood:
- ☐ Mostly in a positive mood
- ☐ Mostly angry or irritable
- ☐ Mostly sad or depressed
- ☐ Mostly anxious or on edge
- ☐ Mostly hyper/out of control

25. Please estimate the effect the current problem has on your child's functioning in the following areas:

	None	***Mild***	***Moderate***	***Severe***
Family	☐	☐	☐	☐
School	☐	☐	☐	☐
Peer relationships	☐	☐	☐	☐
Physical well-being	☐	☐	☐	☐

26. What helps you and your child cope with the problem that brings you here today?

27. Every parent has strengths that help him/her deal with difficult and challenging situations. Please describe your strengths as a parent.

28. How will you know when services are no longer needed? What will you notice you and your child doing differently that is not being done now?

29. Please tell me anything else you think I need to know about you and your child in order to understand your situation.

Thank you! This information is helpful to me in understanding your family's needs.

General Information and Client Consent Agreement

Introduction

Please take your time and read all sections of this disclosure form carefully. Feel free to ask any questions you might have.

Your Rights

You have the right at any time during the course of treatment to request a change of therapy, request a referral for another therapist, or to discontinue therapy for any reason.

Your Responsibilities

- It is important for you to be actively involved in all aspects of treatment including:
- Attending sessions (or letting Malia know when you can't make it)
- Voicing your opinions, thoughts, and feelings, honestly and openly, whether negative or positive
- Being actively involved during sessions
- Doing between-session work as requested
- Experimenting with new behaviors and new ways of doing things

About Your Therapist

Malia Parecki, LCSW, CMHS earned a Master's in Social Work (MSW) from Portland State University in 2008. She has worked as a mental health therapist for individuals, groups, and families since 2002. She is trained to work with people experiencing Depression, Anxiety, Post-Traumatic Stress Disorder, attachment-based concerns, and survivors of abuse/neglect. She works with people across the lifespan, including children, adolescents, adults, and older adults. Malia Parecki is a Licensed Independent Clinical Social Worker **(L4982**) and Child Mental Health Professional in Washington State.

Therapeutic Orientation

I use an integrated approach including aspects of psychodynamic, CBT, EMDR, attachment-based and multicultural therapies as well as mindfulness techniques.

Course of Treatment

Therapy does not necessarily proceed in a neat, sequential, progressive series of steps nor are the stages a predictable length. However, in general there are four steps to therapy.
Assessment: Your therapist will gather your history and work to understand experiences which have impacted you. We will identify goals and agree to collaborate on the problem at hand.
Skill building: You will build skills for managing thoughts and emotions that are overwhelming so you have the tools you need to go deeper into your work.
Insight: We will work together to help you see issues more clearly and see your situation or role differently.
Reorientation: You will work in your everyday life to reinforce new insight and create the life that betters fits your deeper understanding or yourself, your experiences, and your current goals.

If you feel that you are not being helped by therapy or need to terminate therapy for some reason, please discuss this with Malia Parecki at any time during treatment. Malia Parecki may also

request termination if she feels that she is no longer able to help you. However, therapy will never be terminated without discussing these issues with you first.

Treatment Risks

Some clients experience an increase in stress particularly near the onset of therapy. It is not unusual for clients to feel worse before feeling better.

Financial Agreement

Services are charged on an hourly or per session basis. The fee per 50-minute session is $ 125 (except for the first session which is $175). This is payable at the time of our session, unless I have agreed to bill your insurance plan. There will be a $15.00 service charge for each non-sufficient funds check. Accounts are not to accrue any unpaid balance of more than two sessions. After two sessions of unpaid balances, services may be withheld until the account is paid in full. Past due balances may be turned over to a collections agency.

Cancellations, Missed Appointments, and Lateness

A 24-hour advance notice of cancellation for scheduled appointments is required. A $125 fee will be charged for missed sessions not canceled 24 hours in advance. Note: Your insurance will not pay for missed or cancelled sessions, so you will be responsible for paying out of pocket. In addition, if you are more than 20 minutes late, your insurance will not pay for the full session, and you will be responsible for the remainder of the full fee. All messages, including cancellations, may be left on Malia Parecki's voicemail or via text message at (503) 310-6845 or via email at pareckicounseling@gmail.com.

Records

Your records are confidentially maintained in a locking filing cabinet and are placed in secure storage upon termination of services. Each patient's file and records are maintained personally by Malia Parecki.

Please retain a copy of this agreement for your files.

Your signature below indicates that you have read and understood all of the above material and are willing to work within the parameters of Malia Parecki's policies and procedures.

_____

Client Signature Date of Birth Date

_____

Parent/Guardian/Conservator Signature (if applicable) Date

_____

Malia Parecki, LCSW, CMHS Date

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Email and Text (SMS) Messaging Informed Consent

In order to communicate with you by email or text message, I need to make sure you are aware of the confidentiality and other issues that arise when we communicate this way and to document that you are aware of these and agree to them.

I understand that all e-mail messages are sent over the Internet and are not encrypted, are not secure, and may be read by others. I understand that my e-mail communications with my therapist will NOT be encrypted and, therefore, my therapist can NOT guarantee the confidentiality and security of any information we send via e-mail. I understand that SMS messages are even less secure than e-mail, and the same conditions apply. I understand that for this reason my therapist has advised me not to send sensitive information via email or SMS message. This includes information about current or past symptoms, conditions, or treatment, as well as identifying information such as social security numbers or insurance identification information.

I hereby give permission for my therapist to reply to my messages via e-mail, including any information that my therapist deems appropriate, that would otherwise be considered confidential. I agree that my therapist shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet.

I understand that my therapist will limit SMS messages to brief inquiries or responses regarding scheduling. I understand that my therapist may at times e-mail me information about resources that I can use as part of my treatment. I hereby consent to receive such information via e-mail. I understand that e-mail and SMS communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. I understand that if I use email or SMS to make or request scheduling changes it is my responsibility to confirm that my therapist has received my communication more than 24 hours before the appointment time being changed. If I believe I need a response within 48 hours, I will not use e-mail but will call my therapist. If I do not receive an answer to a routine e-mail or text message within two working days, I understand that I should call my therapist. I understand that all e-mail and SMS communications may be made part of my permanent medical record and would be accessible to anyone given access to those records. I also understand that I may withdraw permission for my therapist to communicate with me via e-mail or SMS by notifying my therapist in writing.

_____

Client's Signature

_____

Parent/guardian's Signature (if client is a minor):

_____

Date