Child Intake Information

Please complete the following questionnaire. This information will be discussed more thoroughly in session and used to determine goals for counseling.

Child Patient Name: _____ Date of Birth:_____

Parents' Names: _____ Date of Birth:_____

Address: _____

City, State, Zip: _____

Telephone number(s): Home: (____) _____ Work: (____) _____

Cell: (____) _____ Where can I leave messages? ☐ Home ☐ Work ☐ Cell

Can I contact you by email? ☐ No ☐ Yes Email address: _____

Parent Occupation: _____

Parent Employer: _____

Child Patient's current level of education: _____

Academic Functioning of Patient? _____

Briefly describe your reason(s) for seeking help at this time: _____

_____

_____

_____

_____

What do you wish to accomplish through the process of therapy: _____

_____

_____

_____

Marital/Relationship Status of Patient's Parents (check all that apply):

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Remarried

☐ Single ☐ Long term relationship ☐ Co-habitating ☐ Other: _____

Parent's current partner's name: _____

Partner's occupation: _____

Partner's Date of Birth: _____

Length of relationship: _____

How satisfied are you with this relationship? _____

Do you have any other children (biological, adopted, foster, step, etc.)? ☐ Yes ☐ No

If yes, please list names and ages: _____

_____

_____

Do your children currently live with you? ☐ Yes ☐ No

If no, where do they live? _____

How often do you see them? _____

If you have been previously married, please complete the following:

1st marriage: Date married: _____ Date ended: _____

Children: ☐ Yes ☐ No Ex-spouse's name: _____

Reason for divorce: _____

2nd marriage: Date married: _____ Date ended: _____

Children: ☐ Yes ☐ No Ex-spouse's name: _____

Reason for divorce: _____

Has your child/patient ever been in therapy/counseling before? ☐ Yes ☐ No

If yes, briefly describe the reason(s), dates(s) and length of treatment: _____

_____

_____

_____

Was it a positive experience? ☐ Yes ☐ No What was helpful about it?

_____

_____

Have you or your child ever attempted suicide? ☐ Yes ☐ No

If yes, please describe: _____

_____

Have you or your child ever seriously contemplated suicide? ☐ Yes ☐ No

Are you or your child currently having suicidal thoughts? ☐ Yes ☐ No

Does your child ever hear or see things that other people cannot hear or see? ☐ Yes ☐ No

Has your child ever committed a violent act or crime? ☐ Yes ☐ No

If yes, please describe: _____

_____

Is your child presently taking any medication? ☐ Yes ☐ No

If yes, please describe: _____

_____

What does he/she enjoy doing in his/her spare time? _____

Are there things that s/he used to do, or would like to do, but currently doesn't? _____

How would you describe your spiritual or religious beliefs? _____

_____

Please place a check in front of any of the following that presently cause your child difficulty:

Assertiveness	Health Problems	Career choices	Stomach problems
Parenting	Alcohol use	Legal matters	Self-concept
Bowels	Sexual problems	Marriage	Religion
Nightmares	Loneliness	Concentration	Separation
Energy	Ulcers	My thoughts	Suicidal thoughts
Nervousness	Sleep difficulties	Infertility	Decision making
Physical abuse	Children	Parents	Sexual orientation
Education	Divorce	Relaxation	Infidelity
Temper	Depression	Sexual abuse	Shyness
Stress	Inferiority	Friends	Dating
Memory	Drug use	Headaches	Tiredness
Distractibility	Anger	Impulsivity	Aggression
Finances	Appetite	Anxiety	Unhappiness
Fears	Worry	Work	Confusion
Premarital	Food	Relationships	Self-control
Sadness	Grief/loss	In-laws	My past
Body Image	Pornography	Feelings of rejection	Panic Attacks
Guilt	Eating disorder	Lack of self-confidence	Other:
_____	_____	_____	_____

Please put an * by the items that are causing your child the MOST difficulty.

Is there anything else you think would be important for me to know about your child or your family?

_____

_____

Did someone refer you? ☐ Yes ☐ No If yes, who? _____

May I contact him or her to thank them for referring you? ☐ Yes ☐ No

If you were not referred by someone, how did you find my practice? _____

Treatment Agreement

This document is intended to clarify in writing some of the issues we may have already discussed verbally that need to be brought to your attention regarding our professional relationship. In my work I have found that it is best to specify as well as possible the form and content of our relationship by making a mutual agreement that you may receive the service you desire. It is my assurance that I am well aware and respectful of your basic rights as a consumer and that I will respond to your needs in the most highly ethical manner, according to the standards of care for my profession, mental health and marriage/family counseling. By clarifying the services I have to offer, as the person to be treated, you may best judge whether you desire or are satisfied with them. I remain personally and professionally committed to providing you with the highest quality of service.

Client Rights

As a client of Nicole Story, Ed.S, LMFT, LMHC, Oceanside Family Therapy, LLC you have certain rights which are:

1. To participate voluntarily in treatment with your therapist and to terminate at any time without penalty.
2. To understand that "treatment" could include individual or conjoint therapy for up to 50 minutes (a therapy hour) or a double therapy session for 90 to 120 minutes conducted by your licensed therapist with no absolute guarantee of your desired results by your therapist.
3. To participate with your therapist in exploring your goals as a client and developing a Treatment Plan, which will include the benefits and risks associated with the particular approach to therapy.
4. To have reasonable access to your therapist by telephone in case of emergency.
5. To have information available to you regarding your therapist's professional license and credentials as well as access to the ethical guidelines or "Standards of Practice" in Mental Health Counseling or Marriage and Family Therapy. Your counselor is licensed under Florida Statute 491 of the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling of the Agency for Health Care Administration in Tallahassee, Florida.
6. To be aware that your therapist works as an independent contractor who rents space from other licensed professionals at 4300 Marsh Landing Blvd., Jacksonville Beach, Florida 32250.

7. To understand that, under certain conditions, your therapist may choose to seek supervision from other qualified clinicians.
8. To understand that, in keeping with generally accepted standards of practice, your therapist may confidentially consult with other mental health professionals regarding case management. The purpose of the consultation is to assure quality care, and every effort is made to protect the identity of clients.
9. To have all records and other information concerning to your involvement with this office held in strict confidence and all communication with your therapist privileged, which means that no information is ever to be released to a third party without your written permission. Certain exceptions are: if you are in clear and imminent danger to yourself and others; in child abuse; elder abuse and neglect cases; therapist's subpoena or court order, if you carry and infectious or communicable disease (e.g. AIDS); insurance/third party billing; or if there is a medical emergency.

Client Responsibilities

As a client/consumer, I have carefully read over and signed all of the policies regarding financial responsibilities, making, keeping and cancelling appointments with this therapist and this agreement.

Consent and Authorization for Treatment

I consent to and authorize the assessment and/or treatment that my child will receive as a client of Nicole Story, Ed.S, LMFT, LMHC, Oceanside Family Therapy. I have read the policies of this office and received a copy of them. I understand these rules and policies and agree to follow them. I hereby attest that I have the legal right to authorize treatment for my child.

_____ _____

Signature of Client's Parent/Legal Guardian Date

_____

Printed Name of Client's Parent/Legal Guardian

_____

Printed Name of Child Patient/Client

Financial Responsibility Agreement
Late Cancellation/No Show Policy

As the financially responsible person for the account, I understand that my initial appointment will be 60 minutes, posted and charged at a fee of $150 for couples and $125 for individuals; $100 for each 45 minute psychotherapy individual session thereafter and $125 for couples sessions.

I understand that I will be financially responsible for any charges. I acknowledge that I understand, and accept the terms of the services allowed for mental health treatment.

I understand that I will be charged and am required to pay for phone consults with the therapist which last over 15 minutes, fees based on the 45/50-minute psychotherapy allowable amount.

I understand that I shall keep all scheduled appointments, unless a personal emergency occurs, and shall give at least 24 hours notice of my intention to cancel my appointment.

I understand that if I do not cancel my appointment at least 24 hours in advance (LATE CANCELLATION), or fail to show up for my scheduled appointment (NO SHOW), the first time this occurs I will not be charged. However, if this should occur a second time, I understand that I will be charged. I understand that I will be required to pay for the therapist's full charge for this missed session.

I understand that if my check is returned for insufficient funds (NSF) or other bank reasons, I will be required to pay for this check in cash in addition to a service charge of $35. I also understand that my payments after this will be on a cash or paypal only basis.

I understand and agree that I am ultimately financially responsible for all fees described in this agreement.

_____ _____

Date Client (Legal Guardian or Parent, if minor)

Nicole Story, Ed.S, LMFT, LMHC
Oceanside Family Therapy
328 2nd Ave. N., #100
Jacksonville Beach, FL 32250
(904) 234-0574

Nicole Story, Ed.S, LMFT, LMHC
Licensed Marriage and Family Therapist
Licensed Mental Health Counselor
Qualified Clinical Supervisor, MFT
Qualified Clinical Supervisor, MHC

Oceanside Family Therapy, LLC
328 2nd Ave. N., #100
Jacksonville Beach, FL 32250
Phone (904) 234-0574
Nicole@oceansidefamilytherapy.com
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NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Results of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ AND REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the terms of my Notice to Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy in my office, sending a copy to you in the mail upon request, or providing one to you at your next appointment time.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

1. FOR TREATMENT

2. FOR PAYMENT

I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

3. FOR HEALTH CARE OPERATIONS

I may use or disclose as needed, your PHI in order to support my business activities, including but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (i.e., answering service, billing and accounting service) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI.

4. REQUIRED BY LAW

Under the law, I must make disclosure of your PHI to you upon request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of litigating or determining my compliance with the requirements of the Privacy Rule.

5. WITHOUT AUTHORIZATION

Applicable law and ethical standards permit me to disclose information about you and your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as mental health licensing board or health dept.)

- Required by Court Order

- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

6. VERBAL PROTECTION

I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

7. WITH AUTHORIZATION

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

RIGHT TO AMEND: If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restriction or limitation on the use of disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

RIGHT TO REQUEST CONFIDENTIAL INFORMATION: You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

RIGHT TO A COPY OF THIS NOTICE: You have the right to a copy of this notice.

COMPLAINTS

If you believe that I have violated your privacy rights, you have the right to file a complaint in writing with me or with the Secretary of Health and Human Services at:

200 Independence Ave, SW
Washington, DC 20201

or by calling (202) 619-0257

Nicole Story, Ed.S, LMFT, LMHC
Oceanside Family Therapy

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the "Notice of Privacy Practices" of Nicole Story, Ed.S, LMFT, LMHC. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Nicole Story, Ed.S, LMFT, LMHC.

_____

Signature of Patient/Client's Legal Guardian/Parent Date

☐ Patient/Client Refuses to Acknowledge Receipt

_____

Nicole Story, Ed.S, LMFT, LMHC Date

Life History Questionnaire

The purpose of this questionnaire is to obtain a comprehensive picture of your background. If you do not desire to answer any questions, merely write "Do not care to answer". Feel free to write on the back of the page.

Personal Data

Date of Client's Birth_____ Place of Birth_____

Mother's condition during pregnancy _____

Circle any of the following that applied to your child:

Night Terrors	Bedwetting	Sleepwalking	Thumb sucking
Nail Biting	Stammering	Fears	Happy childhood
Unhappy childhood			

Health during childhood?_____ List Illnesses: _____

_____

Health during adolescence?_____ List Illnesses: _____

_____

What is your child's height?_____ Weight_____ Any accidents:

_____

What are your five main fears?

1._____

2._____

3. _____

4. _____

5. _____

Child's present interests, hobbies, and

activities:_____

_____

How is most of his/her free time occupied?: _____ _____

_____

What is the last grade of school your child has completed? _____

Scholastic abilities, strengths and weaknesses:_____

_____

Was your child ever bullied or severely teased?_____

Does your child make friends easily?_____ Does s/he keep them?_____

If your child uses alcohol or drugs please answer the following:

Does s/he use the following and if so, please state how often (be specific-daily, weekly, monthly, more/less)

Marijuana_____ Nicotine_____ Cocaine_____

LSD_____ Alcohol_____ Prescription Drugs_____

Other_____

How much does s/he use?_____

Has s/he ever been arrested for driving while intoxicated?_____

If Yes, When (Date/s)?_____

Has his/her drug/alcohol use been pointed out by anyone in or outside of the family as a problem? If so, please explain: _____

_____

_____

_____

Does his/her personality change when s/he uses?_____ How: _____

_____

Has his/her behavior become more hostile and caused conflict with anyone else when s/he has been under the influence of drugs/alcohol?_____ With Whom?___

_____

Has your child ever had periods of time that s/he cannot remember the next day after being under the influence of drugs/alcohol?_____ How often does this occur and when is the last time?

_____

Does or has anyone else in your family abused drugs or alcohol? _____ Who and to what extent?

_____

_____

Occupational Data

What sort of work are you doing now?

_____

What sort of jobs have you held in the past?

_____

_____

Does your present work satisfy you? _____ If not, what ways are you dissatisfied?

_____

_____

Sex Information

Any relevant details regarding your child's first or subsequent sexual experiences?_____

_____

Is your child's present sexual behavior age-appropriate?_____ If not, please explain:

_____

_____

Has your child ever experienced any sexual abuse? (*This could include fondling, inappropriate remarks, witnessing adults display sexual behavior, lack of privacy in home, coercion by adults to participate in sexual games, being "checked out" by parents to see if s/he is developing "properly" or having sex, intrusive touching etc):* _____ If yes, please state the circumstances and people involved:

_____

_____

Please state what you did about it: _____

_____

Parent/Family Data (complete as the parent)

Husband/wife/partner's age_____

Occupation of husband/wife/partner_____

Personality of husband/wife/partner in your own words: _____

_____

_____

In what areas is there compatibility? _____

_____

_____

In what areas is there incompatibility? _____

_____

_____

How do you get along with your in-laws (This includes brothers and/or sisters-in-law)

_____

_____

_____

How many children do you have?_____ Please list their sex and ages: _____

Do any of your children present special problems?_____ What?_____ _____

_____

Any relevant details regarding miscarriages or abortions? _____

Comments about any previous marriage(s) and brief details: _____

_____

Has there been any physical violence between you and your spouse/partner or child(ren): _____

If so, please explain the circumstances and the action as well as when this occurred: _____

_____

_____

Has there been any verbal violence or abuse in your family?_____ If so, please explain:

_____

_____

How do you and your partner resolve conflicts or differences? _____

_____

_____

_____

Marital/Relationship Satisfaction Data

What do you like about your relationship/marriage?_____

_____

What do you not like about your relationship/marriage? _____

_____

Parenting Satisfaction Data

What do you like about your parenting abilities? _____

_____

What do you not like about your parenting

abilities?_____

_____

_____

Child Family of Origin Data (complete as the child)

Father

Living or deceased? _____ If deceased, your age at the time of his death: _____

Cause of death? _____ If alive, father's present age?_____

Occupation: _____ Health: _____

Mother

Living or deceased? _____ If deceased, your age at the time of her death: _____

Cause of death? _____ If alive, mother's present age?_____

Occupation: _____ Health: _____

Siblings

Number of brothers:_____ Ages: _____

Number of sisters:_____ Ages: _____

Relationship with brothers and sisters:

Past: _____

Present: _____

Give description of your father's personality with his attitude toward you (past and present):

_____

_____

_____

Give description of your mother's personality with her attitude toward you (past and present):

_____

_____

_____

In what ways were you punished by your parents as a child?

_____

_____

Give an impression of your home atmosphere (i.e the home in which you grew up. Mention state of compatibility between parents and between parents and children): _____

_____

_____

_____

Were you able to confide in your parents? _____ Did your parents understand you? _____

Basically, did you feel loved and respected by your parents? _____

If you have a step parent, give your age when parent remarried: _____

Give an outline of your religious training: _____

_____

If you were not brought up by your parents, who did bring you up, and between what years?

_____

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc?

_____

Who are the most important people in your life? _____

_____

Does any member of your family suffer from alcoholism, epilepsy, or anything which can be considered a "mental disorder"? _____

_____

What was your greatest challenge or difficulty growing up in your family? _____

_____

_____

Goals for Treatment

List the benefits you hope to derive from this therapy: _____

_____

_____

_____

_____

_____

List any situations which make your child feel calm or relaxed:

_____

_____

_____

_____

Please add any information not tapped by this questionnaire that may aid me in understanding and helping you:

_____

_____

_____