

### 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: \_\_\_\_\_

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

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

- Married     Separated     Widowed     Divorced     Remarried  
 Single     Long term relationship     Co-habiting     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:

1<sup>st</sup> marriage: Date married: \_\_\_\_\_ Date ended: \_\_\_\_\_

Children:     Yes     No    Ex-spouse's name: \_\_\_\_\_

Reason for divorce: \_\_\_\_\_

2<sup>nd</sup> 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: \_\_\_\_\_

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

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Have you or your child ever attempted suicide?  Yes  No

If yes, please describe: \_\_\_\_\_

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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: \_\_\_\_\_

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Is your child presently taking any medication?  Yes  No

If yes, please describe: \_\_\_\_\_

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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? \_\_\_\_\_

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How would you describe your spiritual or religious beliefs? \_\_\_\_\_

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**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:

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***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?

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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 a LLC who shares space and support staff with a law firm at 328 2<sup>nd</sup> Ave., 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 I 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.

\_\_\_\_\_  
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; \$100 for each 45 minute psychotherapy individual session thereafter and \$125 for 45 minute couples/family sessions. For rates over 45mins see full rate sheet or rates page on the website.

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-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 \$65. 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.

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Date \_\_\_\_\_ Client \_\_\_\_\_

Nicole Story, Ed.S, LMFT, LMHC  
Oceanside Family Therapy  
328 2<sup>nd</sup> 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**  
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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



### 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?

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**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:

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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:

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Please state what you did about it: \_\_\_\_\_

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**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: \_\_\_\_\_

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In what areas is there compatibility? \_\_\_\_\_

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In what areas is there incompatibility? \_\_\_\_\_

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

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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):

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

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

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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): \_\_\_\_\_

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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:



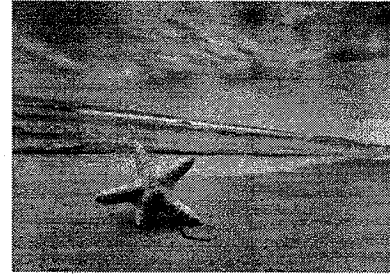
**Oceanside Family Therapy**

*Individual, Couples, Child, Family Therapy & Assessments*

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**Agreement for Confidentiality of Individual Treatment**

I understand that it is Oceanside Family Therapy, LLC's role to provide therapeutic services so that I might feel better and/or improve my functioning, especially as it relates to my family. Oceanside Family Therapy LLC's role is not intended to gather information for the courts or to make judgments related to my family.

Therefore, I agree that I will not call upon Nicole Story, Ed.S, LMHC, LMFT to provide treatment records or to testify in a future divorce or custody action. I understand that courts can appoint professionals who have had no prior contact with my family to conduct independent evaluations and make recommendations to the court.

I understand that it is Oceanside Family Therapy, LLC's policy to have no court involvement in my case because that could harm our professional relationship and the ability to achieve my goals. My goals include resolving personal concerns so that I might preserve my marriage and/or be a better parent. Since I need to speak freely, my spouse is also agreeing never to ask Nicole Story, Ed.S, LMHC, LMFT to testify or have her records of my treatment in court.

By signing this form we are both agreeing not to use any of my therapeutic intervention records or testimony in any future court proceedings.

Signed:

\_\_\_\_\_

Date

Signed:

\_\_\_\_\_

Date