

Stacy Bauman, M.S., LPC
Intake Form for Children and Adolescents

Today's Date: _____

Personal Information

Child's Name: _____

Birth date: ___/___/___ Age: ___ Male Female

Parent(s) Name(s): _____

Address: _____ City: _____ State: ___ Zip: _____

Parent Phone (1): _____ Cell Work Home

Parent Phone (2): _____ Cell Work Home

E-mail Address: _____

What is the best way to reach you?

Parent Phone (1)

Parent Phone (2)

E-mail Address

Your emergency contact person

Name: _____ Relationship: _____

Phone Number (1): _____ Phone Number (2): _____

Religious Preference: _____ This *is* OR *is not* something I consider important for counseling

Important Relationships

Do you currently have full custody of your child? Yes No

(Note: If you answered no, I will need a copy of the divorce decree for my records)

Please list information regarding the child's parents and/or guardians (as applicable):

Mother: _____ Father: _____

Step-Mother: _____ Step-Father: _____

Please list any siblings that the child has:

Sibling (1): _____ Age: ___ Male Female Do they get along well? Yes No

Sibling (2): _____ Age: ___ Male Female Do they get along well? Yes No

Sibling (3): _____ Age: ___ Male Female Do they get along well? Yes No

Sibling (4): _____ Age: _____ Male Female Do they get along well? Yes No
List all people who currently live with the child: _____

Your child's usual living arrangements in the past 2 years (check all that apply):

- With mother and father With mother alone With father alone
 With step-parents With other relatives With foster care
 With adoptive parents No stable arrangements Other: _____

Does your child live with someone who has a current drug, alcohol, or sexual addiction? Yes No

Does your child you have a close, personal relationship with any of the following people (check all who apply)?

- Mother Father Siblings
 Other relatives Friends Teacher(s)

Has your child had periods of significant problems with any of the above? Yes No

Who? _____

Health Information

Is your child currently taking any prescribed medication? Yes No

List names and doses of all medication: _____

Who prescribes these medications? _____

Illegal drugs your child has used: _____ (In last 60 days? Yes No)

Has your child ever been treated for any psychological or emotional problems? Yes No

Is this your child's first time to see a counselor? Yes No

If not, list previous counselors: _____

Has your child ever considered committing suicide or seriously harming him- or herself? Yes No

How many hours of sleep does your child get on average? _____

What activities is your child involved in? _____

Educational Information:

What school does your child attend? _____

What grade is your child currently in? _____ What are his or her average grades? _____

Is there a time currently or in the past when school has been a problem? Yes No

My Concerns

What brings you into counseling today? _____

Please check any of the concerns listed below that apply to your child's life right now. If any of these feel especially important, please circle them or mark them in some way so that we can be sure to discuss them:

- | | | |
|---|---|---|
| <input type="checkbox"/> Abuse (Current) | <input type="checkbox"/> Grief | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Abuse (Past) | <input type="checkbox"/> Guilt | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Hair chewing | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Alcohol or Drug Abuse | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Health concerns | <input type="checkbox"/> Recent move |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hitting | <input type="checkbox"/> Running away |
| <input type="checkbox"/> Arguing | <input type="checkbox"/> Hostility | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Attention span | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> School avoiding |
| <input type="checkbox"/> Bad language | <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Bossiness | <input type="checkbox"/> Immaturity | <input type="checkbox"/> Self harm |
| <input type="checkbox"/> Breaks Rules | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Self-control |
| <input type="checkbox"/> Bullies | <input type="checkbox"/> Inappropriate sexual
behavior | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Bullied by others | <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Conflicts at home | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sibling rivalry |
| <input type="checkbox"/> Conflicts at school | <input type="checkbox"/> Isolating | <input type="checkbox"/> Siblings (other problems) |
| <input type="checkbox"/> Conflicts with friends | <input type="checkbox"/> Bad Judgment | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Conflicts with police | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Spiritual concerns |
| <input type="checkbox"/> Cruel to animals | <input type="checkbox"/> Loss of friends | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Daydreaming | <input type="checkbox"/> Low frustration tolerance | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Deaths | <input type="checkbox"/> Lying | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Decision making | <input type="checkbox"/> Manipulating | <input type="checkbox"/> Temper problems |
| <input type="checkbox"/> Dependence | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Nervous | <input type="checkbox"/> Uncooperative |
| <input type="checkbox"/> Disobedience | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Unhappy |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Violent |
| <input type="checkbox"/> Eating Issues | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Weight issues |
| <input type="checkbox"/> Family concerns | <input type="checkbox"/> Outbursts | <input type="checkbox"/> Wetting/soiling of bed or
clothes |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Oversensitivity | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Yells |
| <input type="checkbox"/> Friendship problems | | |

Use the space below to list any other concerns not listed, or to comment on the concerns above:

Informed Consent for Stacy Bauman, M.S., LPC

Please Initial Each Line:

INFORMATION ABOUT STACY BAUMAN:

_____ I understand that Stacy Bauman is a Licensed Professional Counselor in the state of Texas and holds a Master's of Science in Family Therapy from Texas Woman's University

INFORMATION ABOUT THE NATURE OF COUNSELING AND MY RIGHTS:

_____ **I understand that I am expected to participate in parent sessions on a regular basis, and that these sessions are separate from and in addition to my child's sessions.**

_____ I understand that as the client, I am in control of the counseling relationship and may choose to end that relationship at any time.

_____ I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, my child has the right not to proceed in that assignment.

_____ I understand that counseling can improve as well as upset the equilibrium in any person or family.

_____ I understand that I have the right to speak to Stacy Bauman about ANY concerns that I may have about counseling.

_____ I understand that Stacy may not be available for emergencies. If I need immediate assistance, I will call 911.

_____ I understand that if I have a complaint I cannot solve with Stacy Bauman and I wish to file a formal complaint, I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

INFORMATION ABOUT CONFIDENTIALITY:

_____ I understand that my confidentiality and my child's confidentiality are of utmost importance to Stacy Bauman, and that (aside from the situations listed below) she will keep our privacy in all matters.

_____ **I understand that there are some occasions when confidentiality can or must be breached. Those are: a) I direct Stacy Bauman to share confidential information in writing, b) Stacy Bauman determines that her client poses a danger to self or others, c) she is ordered by a court to disclose information, d) she suspects that child abuse has taken place, at which time she will notify Child Protective Services; or, she suspects elder abuse, in which case she will notify Adult Protective Services.**

_____ I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality. I understand that Stacy will not approach me or my child in public, but that we are free to approach her if we wish.

_____ I understand that confidentiality cannot be guaranteed when communicating through e-mail or over the phone.

INFORMATION ABOUT FEES:

_____ I understand that the fee for counseling covers the time slot of my appointment, and that I will still be charged for that time if I do not give sufficient notice. I further understand that Stacy Bauman is not an in-network insurance provider but is happy to provide an invoice for reimbursement with your insurance provider. **My fee per session is: _____ .**

_____ I understand that if I do not give at least a 24 hour notice in canceling an appointment, I will be charged a fee equal to my usual fee per session (listed above).

_____ I understand that all payment is due at the time of service.

INFORMATION ABOUT TESTING AND PSYCHIATRIC SERVICES:

_____ I understand that Stacy Bauman does not perform formal testing, but refers to individuals who do.

_____ I understand that Stacy Bauman is not a psychiatrist, she is a Master's level therapist, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medical evaluation.

By signing below I confirm that I have read, agreed to and received the above information. I further agree to give my permission for _____ (the child) to receive counseling services from Stacy Bauman, M.S., LPC

Parent/Guardian of Client

Date Received and Read

Stacy Bauman, M.S., LPC

