WESTCHASE OFFICE: Elan Wellness Center, 12197 W. Linebaugh Avenue, Tampa, FL 33626
ST. PETERSBURG OFFICE: Docs Outside the Box! 8950 Dr. MLK St. N, St Petersburg, FL 33716

Kimberly Acheson
MSW, LCSW
License #10560

Intake Form (Under 18)

EAP Authorization and name of Provider: _____ **Policy Number:** _____

Name: _____ Date of Birth: _____ Age: _____

Client Address: _____ City: _____ Zip: _____

School: _____ Grade: _____ Teacher: _____

Parent/ Guardians Information

Name: _____ Parent DOB: _____

Phone: _____ ☐Ok to leave message

Email _____

Email will be used for appointment reminders or scheduling purposes only, not for therapeutic work.

Name: _____ Date of Birth: _____

Phone: _____ ☐ Ok to leave message

Email _____

Email will be used for appointment reminders or scheduling purposes only, not for therapeutic work.

☐Single ☐Married ☐Domestic Partnership ☐Separated ☐Divorced ☐Widowed ☐Other

Are you currently or have plans to enter into the divorce process? ☐ Yes ☐ No

Legal Custody: ☐Joint ☐Sole ☐None Physical Custody: _____

Other People in Child's Home(s)

Name: _____ m/f Age: _____ Relationship: _____

Name: _____ m/f Age: _____ Relationship: _____

Name: _____ m/f Age: _____ Relationship: _____

Name: _____ m/f Age: _____ Relationship: _____

In case of emergency contact: _____

Phone: _____ **Relationship to client:** _____

Referred by: _____

Play Therapy Intake Form

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Your answers to the following questions may provide additional information that will benefit the counseling sessions. Please answer the questions below as honestly and completely you feel comfortable. All answers will be kept confidential. *Thank you for answering these questions, they will assist me in our work together.*

About current needs...

Please mark any of the areas that is currently or has been a concern about your child:

☐Activity Level	☐Hurting Animals	☐Sadness/ Depression
☐Aggression/ Fights	☐Hygiene	☐School Problems
☐Alcohol/ Drug	☐Hyperactivity	☐Self-Harm
☐Anxiety/ Worry	☐Irritability/ Anger	☐Separation Anxiety
☐Bedwetting	☐Lying	☐Sexual Activity
☐Behavior	☐Mood	☐Sleep Problems
☐Change in Appetite / Eating	☐Motor Skills	☐Stealing
☐Destructiveness	☐Nervous Habits	☐Suicidal Thoughts
☐Distractibility	☐Nightmares	☐Suspicious/ Paranoia
☐Fears	☐Play Behavior	☐Temper Tantrums
☐Fire Setting	☐Potty Training	☐Truancy
☐Foster Care/ DHS	☐Relationships with others	☐Weight
☐Height	☐Response to Discipline	☐Other: _____

Please elaborate on the items selected above:

Briefly describe the concern that brings the child to counseling:

When were the concerns first noticed?

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Describe your child's strengths.

How does the child get along with siblings?

Describe child's relationship with caregivers.

Describe any special activities the family does together.

Please describe your child's temperament.

What are child's interactions with others like?

Does your child have friends? What are those relationships like?

Please describe your child's academic strengths?

Does your child have an IEP or a 504 Plan? No

Has your child worked with the School Counselor? No Yes (dates) _____ _____

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How many times has the child moved/ switched schools throughout childhood? How has the child reacted?

Is there anything else you feel is important for me to know about your child?

Family/ Relationship History (Please check any current struggles.)

- ☐Death of Family Member/ Pet
- ☐Differences in Child Rearing
- ☐Drinking/ Drug Abuse
- ☐Marital Problems
- ☐Mental Health of Family Member(s)
- ☐Physical Health of Family Member(s)
- ☐Prolonged Absence
- ☐Separation or Divorce
- ☐ Other _____

Please elaborate on any concerns selected above.

Medical History

Please describe your child's general health.

Are there any medications your child is currently taking/ prescribed?

Please describe any serious illnesses, accidents, or injuries.

Please describe any conditions that require regular medical care.

Has your child previously or currently in therapy or under the care of a psychologist/psychiatrist?

☐ Yes ☐ No Agency / Professional: _____

Dates: _____ Type: _____

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What was your child's birth weight?
_____lbs. _____oz. ☐ Unknown

Was delivery normal? ☐ Yes ☐ Unknown
☐ No (specify) _____

Did the birth mother experience any physical or emotional problems during pregnancy?
☐ No ☐ Unknown
☐ Yes (specify) _____

Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?
☐ No ☐ Unknown
☐ Yes (specify) _____

Did the baby experience any problems immediately after birth? ☐ No ☐ Unknown
☐ Yes (specify) _____

Did caregivers feel bonded to child throughout infancy? ☐ Yes
☐ No (specify) _____

Has your child ever required hospitalization?
☐ No
☐ Yes (specify) _____

Is there any history of physical, sexual or emotional abuse? ☐ No ☐ Unknown
☐ Yes (specify) _____

Is there a history of prolonged separations or traumatic events? ☐ No
☐ Yes (specify) _____

Any disruptions in child's caregiving relationships?
☐ No
☐ Yes (specify) _____

How would you describe your child's approach to new situations?
☐ Positive, jumps right in
☐ Withdrawn, tends to not participate
☐ slow to warm up, cautious

How would you generally describe your child's overall mood?
☐ Positive (happy, laughing, upbeat, hopeful)
☐ Negative (depressed, cranky, angry, hostile)
☐ Mixed but more positive than negative
☐ Mixed but more negative than positive

At what age did your child do the following:
(Parenthesized areas reflect normal development)
_____ smiled (6 months)
_____ sat alone (6 to 10 months)
_____ talked in sentences (30 to 36 months)
_____ walked by self (12 months)
_____ held head up (3 to 4 months)
_____ fed self (2 years)
_____ crawled (6 to 10 months)
_____ rode a bike (6 years)
_____ rolled over (6 months)
_____ talked in single words (18 to 24 months)
_____ pulled self-up (6 to 10 months)
_____ established toilet training (2 ½ to 4 years)

Would you say your child enjoys school? ☐ Yes
☐ No (specify) _____

Is your child currently receiving special services in school? ☐ No
☐ Yes (specify) _____

Has your child ever failed a class or been held back for academic reasons? ☐ No ☐ Yes (specify grade)

Is your child expected to pass this school year?
☐ Yes ☐ No

Consent for Treatment Form

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OUTPATIENT SERVICES CONTRACT Welcome to my practice. I am governed by various laws and regulations and by the code of ethics of my profession. The ethics code requires that I make you aware of specific office policies and how these procedures may impact you. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

COUNSELING SERVICES Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Sometimes counseling services are provided primarily to prevent further deterioration of your mental or emotional status which is considered maintenance treatment. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. Under certain circumstances I may recommend a psychiatric consult; conjoint marital/couple, conjoint parent/child sessions and/or group psychotherapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to refer you to another mental health professional for a second opinion.

MEETINGS I normally conduct an evaluation that will last from 1 to 2 sessions. During this time, we can both decide whether I am the best person to provide the services you need in order to meet your treatment goals. If you decide to continue treatment, I will usually schedule one 60-minute session per week at a time we agree upon.

PROFESSIONAL FEES My hourly fee is $90.00. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you request of me.

BILLING AND PAYMENTS You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. If you wish to pay by check, please make it payable to: Kimberly Acheson.

INSURANCE REIMBURSEMENT In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You should be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide them with additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This record will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do once it is in their hands. In some cases, they may share information with a national medical information databank. Once I have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself (private pay) to avoid the problems described above.

CONTACTING ME I am often not immediately available by telephone. My telephone is answered by an answering service voice mail that I monitor periodically throughout the day. I will make every effort to return your call the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. Telephone calls are offered as a professional courtesy and this service does not constitute an emergency service. I am not responsible for your behaviors or decisions occurring outside the consultation room at any given time, whether before or after a telephone call or consultation. If you are unable to reach me and feel that you can't wait for me to return your call, contact 911, your family physician or the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

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MINORS If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle objections you may have with what I am prepared to discuss.

CONFIDENTIALITY In general, the privacy of all communications between a client and a LCSW psychotherapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police and seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or contact family members or others who can help provide protection. I will take any threats seriously whether I am informed by you or someone you know. Therefore, please use discretion when providing my contact information to a third party. You should be aware that when counseling services are sought by third parties such as employers, lawyers, or the courts, disclosure of some information is required by law. You should also be aware that disclosure of requested information to third parties, when mandated by law, could potentially have an adverse affect on your life. These situations have rarely occurred in my practice. I will make every effort to discuss it with you before taking any action, unless I believe that notifying you may put you or your health in jeopardy.

TERMINATION Your participation in psychotherapy is voluntary and you have the right to withdraw from treatment without adversity at any time. I would recommend that when termination is considered, you discuss this with me, so that we can create a plan for termination to minimize any possible negative effects.

Your signature below indicates that you have read the information in this document, were provided accurate information, and agree to abide by the terms during our professional relationship.

_____
Print Name of Client above line

_____ _____
Signature of Client Date

_____ _____
Additional Client Signature (Spouse/Partner/Friend/Family Member) Date

_____ _____
Signature of Parent/Legal Guardian/ Foster Parent/ Conservator/Other Date

_____ _____
Signature of Psychotherapist - Kimberly Acheson Date