

3102 Golansky Blvd Ste 202  
Woodbridge, VA 22192  
<https://www.holisticcounselinginc.org>  
Phone: 703.239.3268  
Fax: 571.589.0132

## **Child/Adolescent Intake Packet**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of first appt: \_\_\_\_\_

Parent/Guardian (1) Name: \_\_\_\_\_

Parent/Guardian (2) Name: \_\_\_\_\_

### **Describe Guardianship/Custody Agreement (A legal guardian must be present at the intake assessment)**

Please take your time in providing the following information. The questions are designed to help me begin to understand your child so that our time together can be as productive as possible.

**All information provided is confidential.**

#### **Referred by:**

\_\_ Medical Provider: \_\_\_\_\_

\_\_ Insurance Provider: \_\_\_\_\_

\_\_ My Website: <https://www.holisticcounselinginc.org> or PsychologyToday

\_\_ Friend/Family: \_\_\_\_\_

\_\_ Other: \_\_\_\_\_

**Has the patient previously received any type of mental health services?** \_\_Yes \_\_No

If yes, which of the following:

\_\_Psychotherapy \_\_Medication \_\_Outpatient \_\_Hospitalizations \_\_Inpatient Hospitalization

#### **If yes, please provide:**

Name of provider or facility: \_\_\_\_\_

Location: \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

#### **Briefly, what brings your child in today?**

**When did the problem first start?** Within the last: \_\_30 days \_\_6--12 months \_\_2 years \_\_During adolescence \_\_During childhood

#### **What areas of your child's life have been affected because of this problem?**

**Is your child currently experiencing overwhelming sadness, grief or depression?** \_\_Yes \_\_No

If yes, for approximately how long? \_\_\_\_\_

**\*Any Suicidal Thoughts?** Current\_\_ Past\_\_ How long ago? \_\_\_\_\_

Notes: \_\_\_\_\_

**Is your child currently experiencing anxiety, panic attacks or have any phobias?** \_\_Yes \_\_No

If yes, when did your child begin experiencing this? \_\_\_\_\_

**Any History of self-harm?** \_\_Current? \_\_Past? – How long ago? \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Any thoughts about harming others?** \_\_Current? \_\_Past? – How long ago? \_\_\_\_\_

Notes: \_\_\_\_\_

**Please describe any major losses or traumas your child has experienced:**

**What significant life changes or stressful events has your child experienced recently?**

**What would you like to see accomplished during your child's time in therapy?**

### Family History

Please list the patient's **parents, step-parents, siblings, and any other significant family members.**

Please use additional space on the back if needed.

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who has the patient lived with throughout their childhood? \_\_\_\_\_

**In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc).**

Condition	Please Circle	List Family Member
Alcohol/ Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Sexual Abuse	Yes / No	
Eating Disorders	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Disorder	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	

Other diagnosed mental health condition?	Yes / No: Which was?:	
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**Guardians' Marital Status:**

Primary Guardian #1 (PG#1) / Primary Guardian#2 (PG#2)  
 PG#1 / PG#2

- Never Married
- Domestic Partner
- Married

\*\*If married, how long have you been married, and what is your partner's name:  
 (PG#1) \_\_\_\_\_ (PG#2) \_\_\_\_\_

- Separated
- Divorced -- For how long? \_\_\_\_\_
- Widowed: Please provide your partners name and year deceased: (PG#1 or PG#2?-Circle) \_\_\_\_\_

\*Parent(s) currently in a romantic relationship?  
  Yes -- How long? (PG#1) \_\_\_\_\_ (PG#2) \_\_\_\_\_  
  No

What is the patient's Gender? \_\_\_\_\_ Preferred pronoun(s)? \_\_\_\_\_

What is the patient's Sexual Orientation? \_\_\_\_\_

Any issues related to gender or sexual orientation that might be relevant to treatment?

**Physical Health**

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If your child has a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your child's health.

Medication/Supplements	Dosage	Condition	Date Began/Stopped

**Prescribing provider(s) and contact information:**

Name: \_\_\_\_\_  
 Specialty: \_\_\_\_\_  
 Facility: \_\_\_\_\_  
 Phone, email, or Fax: \_\_\_\_\_

**How would you rate the patient's current physical health?**

Poor  Unsatisfactory  Satisfactory  Good  Very Good

**Please list any specific and significant health problems the patient is currently experiencing:**

**How would the patient rate their current sleeping habits?**

Poor Unsatisfactory Satisfactory Good Very Good

**If the patient is having problems, in which phase of sleep are they experiencing issues?**

Falling asleep Staying asleep Awakening early Sleep apnea

**Please list any other specific sleep problems the patient is currently experiencing:**

How many times per week does the patient generally exercise? \_\_\_\_\_ What types of exercise does the patient participate in?:

Is the patient currently experiencing any chronic pain? No Yes If yes, please describe:

### **Substance Use/ Abuse**

**Please describe current use of alcohol, cigarettes, and/or recreational drugs:**

**Please describe previous use of alcohol, cigarettes, and/or recreational drugs:**

### **Additional Information**

**Describe the patient's strengths and limitations related to education:**

**Is there an IEP/504 Plan? Yes No**

**Describe the patient's social relationships:**

**What does the patient enjoy doing in their free time? What do they do to relax?**

**Is the patient spiritual or religious? If yes, please describe their faith or belief:**

**What are some of the patient's strengths?**

**What are some of the patient's weaknesses?**

**Any additional information that might help your child's clinician better understand your child's unique circumstances:**

**Reviewed by :** \_\_\_\_\_  
Print Signed Date

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## **Patient Acknowledgement Receipt of Patient Agreement**

**Please sign, print your name, and date this acknowledgement form.**

By signing below, I hereby acknowledge that I have been provided with the *Holistic Counseling Inc Patient Agreement*. The *Patient Agreement* is available at any time on the HCC website located at:

<https://www.holisticcounselinginc.org>

You may access a copy for review in the HCC waiting room. The Patient Agreement includes explanations of the following:

**Consent for Treatment  
Notice of Privacy Practices  
Financial Policy  
General Office Policies**

"I (Guardian, if patient is a minor) \_\_\_\_\_ have read in full, have been provided adequate opportunity to clarify any questions, understand, and agree to the Holistic Counseling Inc Patient Agreement may be modified without notice. I will discuss these policies with my (or the child's) therapist, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services."

Patient/ (or guardian if minor) Signature:

\_\_\_\_\_

Patient Name: \_\_\_\_\_ Guardian (if minor) Name:

\_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Patient  
DOB: \_\_\_\_\_

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### RELEASE OF MEDICAL INFORMATION

Date of Release \_\_\_\_\_

Dear Dr. \_\_\_\_\_ (Primary Care Physician),

We are currently working with your patient, \_\_\_\_\_, in outpatient mental health counseling. Many insurance carriers require that health information on clients must be obtained. In order to fulfill this requirement, we must request that you either mail or fax the client's latest physical health information.

Mailing address: Holistic Counseling, Inc.  
3102 Golansky Blvd. Ste 202  
Woodbridge, VA 22192

Fax Number: 571.589.0132

Thank you for your prompt attention and your cooperation in this matter. Below you will find the signatures of the client/ guardian indicating agreement with this release.

\_\_\_\_\_  
Signature of Client/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Witnessing

\_\_\_\_\_  
Date

Date Sent to PCP: \_\_\_\_\_

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Fax: 571.589.0132

## GENERAL RELEASE OF INFORMATION

CLIENT NAME: \_\_\_\_\_ DOB \_\_\_\_\_ Date of Release: \_\_\_\_\_

I hereby give my written permission for Holistic Counseling, Inc to exchange the following verbal or written information as indicated with: \_\_\_\_\_ (Name or Entity).

Extent or nature of use/disclosure is limited to: (Check or list all that apply)

Discharge Summary     History & Physical     Psychiatric Evaluation     Progress notes  
 Medical Records     Lab Work     Consultations     Treatment Plan  
 School Records     Psychological Evaluation     Case Coordination     Med Mgmt

Diagnostic Information     Treatment Recommendations

Other: \_\_\_\_\_

Date and/or condition when release will expire: \_\_\_\_\_

If not specified, the release will expire one year from the date signed or 30 days from discharge, if this occurs before one year.

\*As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose, and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations, or eligibility are not conditional upon giving authorization. The original, or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. The authorization is automatically revoked upon termination of service.

The person who receives the records to which this authorization pertains may not redisclose them to anyone else without my separate written authorization unless such recipient is a provider who makes a disclosure permitted by law. A general authorization for the release of medical or other information is not sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or federal law protect the disclosed confidential information. Federal regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Signature (parent signature if client is a minor) \_\_\_\_\_ Date: \_\_\_\_\_

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## CONFIDENTIAL CREDIT CARD INFORMATION FORM

Please use this card for a ONE-TIME payment only

Please put this card on file for copayments / Co-Insurance payments

Name of client: \_\_\_\_\_

Name of card holder (as it appears on card): \_\_\_\_\_

VISA\_\_ MASTERCARD\_\_ DISCOVER\_\_ AMEX\_\_ (HSA cards accepted)

Credit Card # \_\_\_\_\_ Exp Date: \_\_\_\_\_ CCV: \_\_\_\_\_

Zip code associated with this card (billing zip): \_\_\_\_\_

I, \_\_\_\_\_, authorize **Holistic Counseling Inc or HCC**, to charge to charge this card

**for:**

\_\_\_ copayment(s)/ co-insurance(s) due, or  
\_\_\_ for a one-time payment in the amount of: \$ \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_