Baytree
BEHAVIORAL HEALTH

1370 Bedford Drive, Suite 106, Melbourne, FL 32940
Phone: (321) 253-8887 Fax: (321) 253-8878

Child/Adolescent Intake Packet

March 30th, 2017

Dear Client,

Welcome, you have just taken a very positive step by deciding to seek counseling for your child/adolescent. I look forward to helping you and your child/adolescent overcome any current or past challenges, to promote positive growth and balance in your and your child/adolescent's life. If there is a custody arrangement, please be sure to bring a copy of the custody arrangement, and proof both guardians give permission for the child/teen to participate in therapy. I currently do not participate in court appearances. Additionally, we ask your cooperation in filling out the following forms. This information is confidential and will assist myself, the psychologist in assessing your needs. We also need a copy of your driver's license and if you are paying with insurance, a copy of your insurance card.

Thank You,

Dr. Krista Puente Trefz
Licensed Florida Clinical Psychologist
PY7988

Dr. Krista Puente Trefz
Private Psychotherapy Practice

1370 Bedford Drive, Suite 106, Melbourne, FL 32940
Phone: (321) 253-8887 Fax: (321) 253-8878

CHILD INTAKE FORM

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Child's Name:_____ Today's Date:_____

Child's age:_____ Date of Birth (DOB):_____

Address:_____

_____

Parent's Name: _____ Parent's Name: _____

Home phone:_____ May I leave a message? Yes No

Cell phone:_____ May I leave a message? Yes No

Work phone:_____ May I leave a message? Yes No

Email: _____ May I email you? Yes No
(For appointment scheduling purposes only, as email not considered a confidential medium of communication).

INSURANCE INFORMATION

Insurance Company:_____ Name of Insured:_____

Insured's Date of Birth: _____

Insured's Employer:_____ Policy Name: _____

Insured's Member ID #:_____ Insured's Group #: _____

Insured's Relationship to the Client:_____ Authorization # (if needed):_____

Customer Service Phone # (for MH/SA): _____

Address for Submitting Claims: _____

Who referred your child to my private practice? Please provide agency/professional's name & tel #:

_____

May I contact the agency/person to thank them for referring you? Yes No Please initial:_____

What is the <u>main reason(s)</u> you're seeking help for your child? (Include how long he/she's had these symptoms or problems):

_____

_____

_____

What are your hopes/treatment goals regarding your child/teen's therapy?_____
_____
_____

If your child/teen had difficulties in the past, what have they done to cope? Was it helpful?

_____

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems? _____

_____

_____

Has your child ever been treated for any of the following? If so please circle and describe:
Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions:

_____

_____

_____

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

_____
_____
_____

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

_____

_____

Please list your child's current prescription medications with dosage (psychiatric and general health):

_____

_____

Please list any previous psychiatric medications (with dosage and dates): _____

_____

Do you suspect or know your child drinks alcohol or uses recreational drugs? If so, what kind & how often?
_____

_____

Do you or anyone close to your child consider his/her use to be a problem? Yes No

Who is your child's primary care physician? _____

Who is your child's psychiatrist (if applicable)? _____

When was your child's last complete physical exam (mo/year)? _____

For women adolescent's only: Date of last menstrual period _____
Is your daughter currently pregnant or do you think she might be pregnant? ( ) Yes ( ) No.
Is your daughter on Birth control _____

Date and place of last physical exam:

_____

How many times a week does your child exercise? _____What type & how many minutes? _____

_____

What type of exercise does your child prefer?_____

Does your child participate in any after school clubs or sports teams?_____

Does your child attend any exercise classes in the community?_____

Does your child participate in any community lead sports or clubs?_____

What types of food does he/she often eat? _____

_____

How often does your family sit together during a meal?_____

How often does your child sit in front of the t.v./electronics/ipad during a meal?_____

YOUR CHILD'S FAMILY

	BIOLOGICAL MOTHER	**BIOLOGICAL FATHER**
Current age, or If deceased date, age, & cause of death		
Country of Origin		
Occupation		
Religious/Spiritual Affiliation (if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? _____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:__

_____

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

YOUR CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth:

Where there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe:

_____

Medications used during pregnancy? Please list: _____

Smoking? Yes No How much? _____

Alcohol intake? Yes No How much? _____

Drug intake? Yes No How much? _____

Length of pregnancy?_____Weeks Age of mother at birth: _____ Birth weight: _____

Were there any complications during delivery? If so, please describe: _____

_____

Length of stay in the hospital? Mother: _____(days) Child: _____(days)

Developmental Milestones and Early Development:

At what age did your child do the following (indicate approximate month or year of age for each):

Turn over _____ Crawl _____ Stand Alone_____ Walk Alone _____

First Words _____ First Phrases_____

Toilet trained? Yes No If yes, days?_____Nights? _____

Has your child wet or soiled himself after being trained? Yes No If yes, until what age?_____

Enjoyed cuddling? Yes No Fussy, Irritable? Yes No More active than other babies? Yes No

If your child has siblings, was development different in any way? Explain:_____

_____

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics:

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

School name: _____Public or Private (circle one)?

Street Address: _____

School District/County? _____ Phone: _____(___)_____

What preschool experience did your child have? _____

Where any problems detected in your child's kindergarten screening? Yes No If so, please explain:

_____

Is your child in a regular classroom? Yes No Does your child have an IEP ? Yes No

Has your child ever received tutoring? Yes No If so, please explain: _____

What are your child's typical grades? _____

What are your child's strongest and weakest points academically? _____

_____

Are you satisfied with your child's educational program? Yes No Please explain: _____

_____

Home/Family Life:

What are 5 things that you enjoy most about your child? _____

_____

What are some activities you engage in as a family? _____

Does your child participate in any religious or faith based group? _____

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques? _____

_____

Please briefly describe your relationship with your child/teen_____

Please describe your child/teen's relationship with her/his father_____

Who does your child/teen confide in?_____

How is the environment of the home?_____

Is there any current or past domestic violence?_____

Is there any current or past child abuse, sexual abuse or neglect in regard to your child/teen?_____

How does your child get along with his/her sibling(s)?_____

What are <u>your</u> strengths personally and as a parent? _____

What are some of <u>your</u> areas of needed growth? _____

What are your <u>child's</u> strengths (things he/she is good at)? _____

What are your <u>child</u>'s areas of needed growth? _____

Social and Community Engagement:

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activities is he/she involved? _____

How does your child get along with other children? _____

Who are some of your child's closest friends (first name) _____

_____

Legal History:

Has your child/teen you ever been arrested? _____

Does your child/teen have any pending legal problems? _____

Have the police been called to your home for any reason recently or in the past?_____

Your Child's Symptoms or Problems:

How much are <u>each</u> of the following areas currently a problem for your child?

	Not at all **1**	**A little** **2**	**Somewhat** **3**	**Considerably** **4**	**Terribly** **5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? Yes No
(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No

If yes, please describe:_____

_____

_____

Does your child/teen have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No. Please describe when, where and by whom:

_____

Suicide Risk Assessment:

Has your child/teen ever had feelings or thoughts that they expressed to you or someone else they didn't want to live? **( ) Yes ( ) No**. If YES, please answer the following. If **NO**, please skip to the next section.

Does your child/teen currently feel he/she doesn't want to live? **( ) Yes ( ) No** How often does your child/teen have these thoughts? _____

When was the last time your child/teen had thoughts of dying? _____

Has anything happened recently to cause your child/teen to feel this way?

_____

Has your child/teen expressed any suicidal plans? _____

Is the method she/he would use readily available? _____
Is there anything that would stop your child/teen from killing herself/himself? _____
Has your child/teen ever tried to kill or harm herself/himself before?
_____
Does your child/teen have access to guns? If yes, please explain. _____
Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child/teen: _____
_____
_____
_____
_____

Do you wish for Dr. Trefz to have the ability to share any of your child/teen's therapy progress with their pediatrician, school, or psychiatrist?_____

If so, please be sure to request & complete the necessary forms at the front office to provide the release of information (complete with the specific medical person, & their contact information).

Parent Signature_____Date_____

Please print name as well_____

Emergency Contact _____ Telephone # _____

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Phone: (321) 253-8887 Fax: (321) 253-8878

Dr. Krista Puente Trefz

No-Show and Late Cancellation Policy:

Working with you and/or your family to help you achieve your therapy goals is very important to me. It is understandable that there may be scheduling conflicts that arise during treatment. Baytree Behavioral Health's administrative staff will work hard to try to accommodate any scheduling conflicts that may arise. The more advanced notice you can provide, the more accommodating we can be to try to find an alternative time that will meet your needs. Due to the high demand for psychological services, any no-shows or cancellations with less than 24-hour notice will be assessed a fee. We appreciate your cooperation with this matter and look forward to providing you and your family with mental health services. Effective immediately, all appointments that result in a no-show or late cancellation will be charged a $50 fee. Due to the high demand for afternoon appointments, those scheduled for 2:30 p.m. or later will be charged a $100 fee. This charge will be your responsibility and cannot be billed to your insurance company. Thank you for your cooperation-*Dr. Krista Puente Trefz*

I acknowledge that I have read and understand the no-show/cancellation policy as defined above.

_____

Printed Name of Client/Guardian

_____ _____

Signature of Client/Guardian *Date*

Baytree Behavioral Health
Orientation to Clinical Services

Following is an outline of items and issues which will be discussed in our first clinical meeting. These issues are discussed early in the therapeutic process to facilitate a clear understanding of the many factors which influence the clinical work we do together. They are established to ensure the highest quality of care. Any time you have questions regarding these policies and procedures, please feel free to discuss them in therapy. All of our administrative practices are in compliance with the Health Insurance Portability and Privacy Act (HIPPA).

1. CONFIDENTIALITY: Some exceptions to maintaining confidentiality include:
   - Insurance processing (limited information necessary to process claim)
   - Discussions with other clinical professionals in private anonymous consultation
   - In the case of child abuse
   - Suicidal or homicidal plan, action, or intent
   - Disclosure of violent crimes or of threat or intent to harm others
   - Other individuals, only with your written consent

2. EMERGENCIES:
   - Contact the clinic during normal business hours
   - The clinic or answering service will contact your therapist. After-hours emergency phone sessions will be charged private pay in increments of 15 minutes. Price depends on the provider.
   - Go to the nearest Emergency Room

3. APPOINTMENTS:
   A clinical therapy appointment can be expected to be 45 minutes in length and I make every attempt to start the appointment on time. From time to time, clinical needs may dictate adjustments, but every effort will be made to avoid delays.

4. CANCELLATIONS:
   Many times there are patients on a waiting list to see a therapist. Subsequently, there is a $50 charge for appointments missed or appointments not canceled within 24 hours of the appointed time. This fee cannot be charged to insurance and is the responsibility of the patient.

5. INSURANCE:
   If financial conditions make it necessary to adjust service fees or co-pays, the insurance company must be notified of such an adjustment. It is unethical and constitutes insurance fraud if a co-pay is waived without the insurance company's awareness. Patients are responsible for the payment of their co-pays and deductibles at the time the service is rendered. If the insurance company refuses to pay, the patient is responsible for the cost related to the services. Baytree Behavioral Health will not bill tertiary insurance for patients. Costs not covered by primary/second insurance will be the patient's responsibility.

6. TRAINING INSTITUTE:
   Periodically, we may supervise mental health professionals in training who may be involved in various aspects of the therapeutic process. Their clinical participation is critical to the development of quality clinicians. They, of course, follow the same rigorous rules regarding confidentiality and your permission is always requested.

Please read and sign:

I hereby fully understand that I enter into treatment having discussed the nature of the therapeutic relationship, the therapeutic course, and techniques to be used, to include therapeutic risks and benefits. I am aware of issues relating to confidentiality and its exceptions, patient's rights and responsibilities, the established fees, insurance company requirements, and policies related to “no shows” and cancellations. I have had the opportunity to review the Privacy Act Policies of the clinic and I am also aware that I may discuss these issues at any time.

_____ _____

(Patient Signature) (Date) (Print Name)

Baytree Behavioral Health Notices of Privacy Practices

I have read and understand Baytree Behavioral Health HIPAA Practices and my rights and responsibilities as they pertain to my treatment record at Baytree Behavioral Health. I am also aware that upon request I may receive a hardcopy of this Privacy Notice.

Patient Signature:

Patient Representative:

Witness:

Date:

Date: _____

Patient Name: _____

I have been provided information on the following:

Patient Privacy Statement (HIPAA)

I Accept _____
(Patient Signature)

Benefits & Release: I authorize the billing of my insurance company for services provided.
*(For Medicare/Tricare patients: Your plans are **almost always secondary to any other commercial insurance**. Failure to disclose other insurance is illegal and could result in charges not being covered by either insurance, becoming patient responsibility.)*

I Accept _____
(Patient Signature)

Patient Financial Policy

Note: No-shows or cancellations with less than 24 hours notice are subject to a $50 fee

I Accept _____
(Patient Signature)

For Tricare Patients Only

Baytree Behavioral Health
Office: 321-253-8887 / Fax: 321-253-8878
CONSENT TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

I, _____ (DOB_____), hereby authorize
Baytree Behavioral Health, located at 1370 Bedford Dr., Suite 106, Melbourne, Florida 32940,
_____ **to release to** _____**to receive from** (check appropriate line)

Person/facility/agency: **45th Medical Group Patrick AFB**
Fax/Phone: **P: 321-494-7599 F: 321-494-8334**
Address if known: _____
The specific information indicated below with regard to the services provided to me for the period of treatment from _____(all dates included)_____ for the following purposes:
____For coordination of care
____For treatment at this facility
____For processing of my insurance claim
____For peer review/third party payer
____Other (specify): _____
Information to be furnished (this section must be completed)
Check/Initials

_____Progress reports throughout treatment
_____Report of psychological/psychiatric evaluation
_____History and Physical
_____Medical Discharge Summary
_____Psychosocial Assessment
_____Continuing Care Plan
_____Progress Notes
_____Neuropsychological Assessment
_____Lab and Radiographic results
_____Consultations
_____Legal
_____Other: Specify_____

I understand that the above consent is subject to revocation by me at any time except to the extent that action has been taken in reliance on this consent prior to revocation. The Federal Regulations regarding the confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR part 2) have been explained to me as applicable.

_____ or _____
Patient Signature Parent/Legal Guardian

_____ _____
Witness Date

****

I do not want my records released to Patrick Airforce Base.

_____ or _____
Patient Signature Parent/Legal Guardian

_____ _____
Witness Date