Positive Connections, LLC
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Kansas City, MO 64111
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Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with his/her therapist. This means that some of the issues that they discussed in session will stay between us, and that I will not disclose that information to anyone, including you, unless I have been given permission by your child to do so. It is important for your child to be open and honest in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. It is also very important for you to know what your child is going through in order to do your job as a parent, which is why I will always encourage your child to be honest with you. I will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

Please know that this confidentiality has limits. If there is any threat to your child's life, I have the duty to inform you and help to create a plan for safety.

In addition, there are situations that I am mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.

Finally, I recognize how challenging it can be for a parent to raise a child, especially when the child has a mental illness. I know how badly you might want to know everything your child has kept a secret from you, too. I want to be your partner in supporting your child's physical and mental wellbeing, and even when I can't discuss certain details about your child with you, I will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.

Welcome to therapy. Please note that the information is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (ages 12-17)

Adolescent please fill out pages 2-6, parent/guardian please fill out pages 7-11

CLIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____ Male _____ Female _____

Phone (Cell): _____

Messages okay?___ Text reminder okay?_____

School: _____ Grade: _____

Please Share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) that you use:

_____

Do your parents have access to your electronic communication? (Y/N

Do they have any issues with your use of phone, text, electronic communication? (Y/N)

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

_____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling?

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? Yes No

If yes, what did you find most helpful in therapy?

_____

If yes, what did you find least helpful in therapy?

_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? Yes No

If yes, how often do you drink? _____Daily, _____Weekly, _____Occasionally, _____Rarely

If yes, how much do you drink? _____(#) per time.

Do you currently use Tobacco? Yes No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? Yes No

If yes, what drugs do you use?

_____

If yes, how often do you use? _____Daily, _____Weekly, _____Occasionally, _____Rarely

Have you received any previous treatment for chemical use? Yes No

If so, where did you go?_____

____Inpatient _____Outpatient

Adolescents (please answer the following with Y/N)

1. Have you ever used more than 1 chemical at the same time to get high? _____

2. Do you avoid family activities so you can use? _____

3. Do you have a group of friends who also use? _____

4. Do you use to improve your emotions such as when you feel sad or depressed?? _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

_____

FAMILY HISTORY

1. Are your parents married or divorced? _____

2. Do you think their relationship is good? (Y/N/Unsure)_____

3. If your parents are divorced, whom do you primarily live with? _____

4. How often do you see each parent? Mom_____% Dad _____%.

5. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

FAMILY CONCERNS

(Please check any family concerns that your family is currently experiencing)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education Problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change		Job dissatisfaction

Other concerns not listed above _____

PEER RELATIONS

1. How do you consider yourself socially: ___outgoing ____shy ____depends on the situation.

2. Are you happy with the amount of friends you have? (Y/N)_____

3. Have you ever been bullied? (Y/N) _____

4. Are your parents happy with your friends? (Y/N)_____

5. Are involved in any organized social activities (e.g. sports, scouts, music)?

_____

SCHOOL HISTORY

1. Do you like school? (Y/N)_____

2. Do you attend regularly? (Y/N)_____

3. What are your current grades? _____

4. Do you feel you are doing the best you can at School? (Y/N) _____

INDIVIDUAL CONCERNS CHECKLIST

SYMPTOM	None	Mild	Moderate	Severe
Sadness				
Crying				
Sleep Disturbances				
Problems at home				
Hyperactivity				
Binging/Purging				
Loneliness				
Unresolved Guilt				
Irritability				
Nausea/Indigestion				
Social Anxiety				
Self-Mutilation				
Cutting				
Impulsivity				
Nightmares				
Hopelessness				
Elevated Mood				
Mood Swings				
Disorganized				
Anorexia				
Grief				
Phobias				
Headaches				
Weight Changes (unplanned)				
Appetite Changes				
Social Isolation				
Paranoid Thoughts				
Poor Concentration				
Indecisiveness				
Low Energy				

SYMPTOM	None	Mild	Moderate	Severe
Excessive Worry				
Low Self Worth				
Anger Issues				
Spiritual Concerns				
Hallucinations				
Racing Thoughts				
Restlessness				
Drug Use				
Alcohol Use				
Easily Distracted				
Trauma Flashbacks				
Obsessive Thoughts				
Panic Attacks				
Feeling Anxious				
Feeling Panicky				
Suicidal Thoughts				
Past Suicidal Attempts				
Other				

If you would like to add any additional information, use the space below.

Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: _____ Date of Birth: _____ Age: _____

Male _____ Female _____ Race/Ethnic Origin: _____

Religious Preference: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship	Age	Sex	Type (bio, step, etc)	Living with you?

(If additional space is need please list on the back of page)

Current Reason For Seeking Counseling For Your Adolescent.

Briefly describe the problem for which your adolescent is seeking to have counseling for?

_____

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

What is most concerning right now?

_____

_____

CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe:

_____

2. Did your child have health problems at birth? Yes _____ No _____ If yes, describe:

_____

3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

Yes ___ No ___ Not sure_____ If yes, describe:

_____

4. Did your child have any unusual behaviors or problems prior to age 3?

Yes ___ No ___ Not sure_____ If yes, describe:

_____

5. Has your child experienced emotional, physical, or sexual abuse?

Yes ____ No ____ Not sure _____ If yes, describe:

_____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? Yes _____ No_____ If Yes, where:

_____

Approximate Dates of Counseling:

_____

For what reason did your son or daughter go to counseling?

_____

Does your son or daughter have a previous mental health diagnosis?

_____

What did you find most helpful in therapy?

_____

_____

What did you find least helpful in therapy?

_____

_____

Has your son or daughter used psychiatric services? Yes____ No____ If yes, who did they see?

_____

If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern?

Yes_____ No _____

Name of medication _____ Dates taken _____ Was it helpful? (Y/N)

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N

If so, please describe.

_____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____

If yes, please explain your concern:

_____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____ If yes, please explain your concern:

_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

_____

FAMILY HISTORY

Are you aware of any birth trauma your son or daughter experienced from age 0-3?

_____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

_____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

_____

_____

PARENT'S MARITAL STATUS

___ Single ___Married (legally) ___ Divorced ___Cohabitating ___Separated ___Widowed

___Other Length of marriage/relationship:_____

If divorced, how old was your child at time of divorce? _____

If divorced, How much time does your child spend with each parent? Mother___%, Father ___%

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

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	Job change		Job dissatisfaction

Other concerns not listed above _____

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

_____

_____

What personal qualities would you say your son or daughter has?

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe)

_____

_____

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