Client Name: _____
Client ID#: _____

ADOLESCENT/ CHILD INTAKE FORM

Child's Name: _____ Age: _____ DOB: _____
Sibling: _____ Age: _____ DOB: _____
Sibling: _____ Age: _____ DOB: _____
Sibling: _____ Age: _____ DOB: _____
Sibling: _____ Age: _____ DOB: _____

1. Parent's Name: _____ DOB: _____
Address (City, State and Zip): _____
Marital Status: _____ Male/Female: _____
Phone: H(____)_____ W(____)_____ C(____)_____
OK to say BBHP? Yes_____No_____
Emergency contact (name and phone #) _____
Email: _____
I would like to receive email updates from BBHP ☐**Yes** ☐**No**

2. Parent's Name: _____ DOB: _____
Address (City, State and Zip): _____
Marital Status: _____ Male/Female: _____
Phone: H(____)_____ W(____)_____ C(____)_____
OK to say BBHP? Yes_____No_____
Emergency contact (name and phone #) _____
Email: _____
I would like to receive email updates from BBHP ☐**Yes** ☐**No**

3. Step Parent(s)/Guardian(s): _____ DOB: _____
Address (City, State and Zip): _____
Marital Status: _____ Male/Female: _____
Phone: H(___)_____ W(___)_____ C(___)_____
OK to say BBHP? Yes_____No_____
Emergency contact (name and phone #) _____
Email: _____
I would like to receive email updates from BBHP ☐**Yes** ☐**No**

****

History of Problem

Please describe what concerns you have regarding yourchild: _____
_____
_____

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Name:_____
Client ID#: _____

How long has the problem existed? _____

_____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

_____

_____

_____

What attempts have been made to resolve the difficulties? _____

_____

Please check the symptoms that the child is currently experiencing. Please indicate to which family member you are referring, as well as duration, and severity.

		Severity of symptom		
		None	*Mild*	*Moderate*	*Severe*
		0	*1*	*2*	*3*
Symptom	*Name(s)*		*How Long?*	
Sadness or Depression				
Suicidal Thoughts				
Sleep Problems				
Changes in Appetite				
Weight Change				
Inability to Concentrate				
Obsessive Thoughts				
Tension and Anxiety				
Panic Attacks				
Memory Problems				
Compulsive Behaviors				
Feelings of Hostility				
Acts of Violence				
Social Isolation				
Strange Thoughts				
Stomach Aches				
Head Aches				
Bed Wetting				
Phobias				
Others				

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Name:_____
Client ID#: _____

Parent Information

Are there any other agencies involved with the family (CPS, Child Welfare, Courts, etc.)?

_____

_____

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)_____

_____

_____

Is ex-spouse (biological parent) aware that you are bring their children to BBHP? ☐**Yes** ☐**No**

If not, please explain._____

_____

_____

If adopted, does child know of adoption? ☐**Yes** ☐**No**

What age was your child at the time of the adoption?_____

Mother's Name:_____Age:_____Occupation:_____

Employment status:_____Employer's name and address: _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

_____

History of alcohol/drug use? _____

History of arrest? _____

Primary Care Physician: _____

Psychiatrist: _____

Father's Name:_____Age:_____Occupation:_____

Employment status:_____Employer's name and address: _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

_____

History of alcohol/drug use? _____

History of arrest? _____

Primary Care Physician: _____

Psychiatrist: _____

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Name:_____
Client ID#: _____

Step-parent/Guardian:_____Age:_____Occupation:_____
Employment status:_____Employer's name and address: _____
_____
Significant medical problems: _____
Serious illnesses, accidents, or surgeries inthe past: _____
Current and past psychiatric treatment or counseling: _____
Currently prescribed medications: _____
Current alcohol/drug use (amount, how often, intoxication frequency): _____
_____
History of alcohol/drug use? _____
History of arrest? _____
Primary Care Physician: _____
Psychiatrist: _____

Child Information (including siblings):

1). Name of Sibling:_____ Age:_____Child lives with: _____
School:_____Grade:_____Teacher:_____
History of psychiatric treatment or counseling: _____
Current or past drug or alcohol use (indicate past or present amount, frequency) _____
_____
Significant medical problems: _____
Serious illnesses, accidents, or surgeries inthe past: _____
Medications currently prescribed: _____
Pediatrician:_____
Psychiatrist: _____

2). Name of Sibling:_____Age:_____Child lives with: _____
School:_____Grade:_ Teacher:_____History of psychiatric treatment or counseling: _____
Current or past drug or alcohol use (indicate past or present amount, frequency) _____
_____
Significant medical problems: _____
Serious illnesses, accidents, or surgeries inthe past: _____
Medications currently prescribed: _____
Pediatrician:_____
Psychiatrist: _____

3). Name of Sibling: _____Age:_____Child lives with: _____
School:_____Grade:_ Teacher:_____History of psychiatric treatment or counseling: _____
Current or past drug or alcohol use (indicate past or present amount, frequency) _____

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Name:_____
Client ID#: _____

Significant medical problems: _____
Serious illnesses, accidents, or surgeries inthe past: _____
Medications currently prescribed: _____
Pediatrician:_____
Psychiatrist: _____
Please list any additional siblings on the back

How did you hear about BBHP? _____

WHEN ARE YOU AVAILABLE FOR A WEEKLY APPOINTMENT? (☑ all availability)						
60 Minute Sessions	MON	TUES	WEDS	THURS	FRI	SAT
9am, 10am, 11am, 12noon						
1pm, 2pm, 3pm, 4pm						
5pm, 6pm, 7pm, 8pm						

Consent for Treatment of a Family or a Child

Please read carefully

This is to certify that I give permission to Bloom Behavioral Health Partners (BBHP) for my family or child's participation in therapy. The names of the family members in therapy are outlined below. Additional children may be listed on the back of page 2.

Name of Child:_____ Date of Birth:_____ Age: _____

Name of Child:_____ Date of Birth:_____ Age: _____

Mother's /Legal Guardian's Name:_____ Date of Birth:_____ Age: _____

Father's/Legal Guardian's Name:_____ Date of Birth:_____ Age: _____

I. Fees and Appointments

1. Appointments are 55 minutes, and ordinarily take place one time per week.If your family/child is unable to keep an appointment, please contact their counselor to cancel as soon as possible.
2. Benefits will be obtained prior to your first appointment. We ask that you pay your counselor at the beginning of each session for any copays, deductible balances, etc. We reserve the right to suspend therapy for services rendered and not paid for.
3. You **are allowed one no-call no-show. After the first missed appointment that you did not give 24 hours notice, you will be charged $45 for each missed appointment.**
4. **If you need to reschedule an appointment and have not contacted your counselor at least 24 hours prior, you will be responsible for a partial fee of $25. Too many late cancellations/reschedules can result in being discharged from the practice.**
5. You can and should discuss any concerns regarding your financial status with your counselor especially if your financial situation should change or improve.

II. Confidentiality

1. Communication between you and your family/child's counselor is both privileged and confidential. This means that without your written permission the counselor cannot discuss your family/child's case orally or in writing, except with **Bloom Behavioral Health Partners** clinical supervisors and staff.
2. Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:
   a. If there is a reason to believe there is an occurrence of child, elder or dependent adult abuse or neglect.
   b. If there is reason to believe that your child or a member of your family has serious intent to harm themselves, someone else, or property by a violent act they maycommit.
   c. If you introduce a family member's emotional condition into a legal proceeding, or your counselor is subpoenaed to give testimony.
   d. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
   e. If there is a court order for release of your records.

Client name: _____
Account #: _____

III. Counselor Availability and After Hours Emergencies

Counselors check for voice mail messages during normal business hours. Messages left outside of normal **BBHP** hours of operation will be picked up the next business day. If you have an emergency that needs immediate attention you may need to seek assistance at the nearest emergency services department.

IV. Client Rights and Responsibilities

1. You have the right to end your family/child's therapy at any time, for whatever reason, without any obligation except for fees already incurred.
2. You have the right to question any aspect of your family/child's treatment with your counselor and to expect that we will work with you to meet your needs for adjunctive or alternative treatment.
3. If your child sees a counselor individually, you have the right to expect that their counselor, as requested, will communicate with you about your child's therapy. However, as the establishment of trust between your child and their counselor is important for a successful therapeutic outcome, we ask you to keep in mind your child's need for privacy.
4. *I realize that if my child is seen in therapy, both parents may be asked to participate in the treatment. This may involve family treatment, parent meetings between you and your child's therapist, or individual therapy for each parent. Your therapist may share information regarding issues that arise in the course of the therapy with either parent.*
5. You have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, which would greatly compromise the therapeutic relationship.
6. Therapy involves a partnership between therapist and client. Your family's therapist will contribute knowledge, skills, and a willingness to do his/her best. The determination of success, however, is largely dependent upon your commitment to your family's personal growth and care. Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to **BBHP** to provide counseling services and that this contract is binding for all future sessions you may have with this agency.

Signature of Parent/Legal Guardian #1:_____ Date: _____

Signature of Parent/Legal Guardian #2:_____ Date: _____

Client name: _____
Account #: _____

Adolescent Counseling Information

What to expect from therapy:
You can expect that I will do my best to understand your concerns. I will listen without judgment and provide an opportunity for you to learn more about yourself and hopefully together we will find better solutions to the challenges in your life.
You can expect that what we discuss will be kept private.

There are a few exceptions, and here they are:

1. You tell me that you plan to commit suicide or great bodily harm to another person.
2. You tell me that you are being abused physically, sexually, or emotionally, or that you have been abused in the past.
3. You are involved in a court case and a request is made for information about your counseling or your therapy.
4. You tell me that you are or have engaged in a sexual relationship with someone who is significantly older than you. In most cases I would be required by law to report this to Child Protective Services.

What to expect about my communications with your parent or guardian: Generally speaking… I will keep the specifics of what you share with me private.

There are few exceptions, and here they are:

1. If I do hear that you are involved in risk-taking behavior that becomes serious, then I will need to use my professional judgment to decide whether I must inform your parent/guardian, or we will discuss how to share this with your parent(s) together.
2. Even though I am committed to keeping your information confidential, I may believe that it is important for your parent/guardian to know what is going on in your life. In these situations we will work together to find the best way to discuss these things with your parent(s).
3. When meeting with your parents I will discuss challenges and progress that you have made in counseling. Generally speaking, I will talk about themes rather than specifics. The purpose of meeting with your parent(s) is to support our work together and to facilitate improved family relationships.

What I expect from you:

1. You agree to attend therapy sessions as scheduled and participate to the best of your ability.
2. You agree to participate in goal setting and take an active role in making positive life changes.
3. You agree to talk with me if you have thoughts or feelings about harming yourself or someone else.

Bloom
Behavioral Health

Client name: _____
Account #: _____

What I expect from your Parent/Guardian:

1. You agree to support your child's treatment by doing your best to arrange for regular attendance.
2. You agree to make yourself available for parenting consultations and/or family meetings as requested by your child or his/her counselor.
3. You agree to be supportive of the counseling process.

Counselor's Signature: _____ Date: _

Minor's Signature: _____ Date: _

Parent Signature: _____ Date: _

Parent Signature: _____ Date: _

Bloom
Behavioral Health

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACYPRACTICES

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

In the course of providing services to you, we may create, receive, and store individually identifiable information, including information that relates to health care and payment for health care ("Personal Information"). It is often necessary to use and disclose this Personal Information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a HIPAA Notice of Privacy Practices that describes these uses and disclosures. As described in our Notice of Privacy Practices, the use and disclosure of your Personal Information for treatment purposes not only includes care and services provided here, but also disclosures of your Personal Information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your Personal Information for purposes of payment may include, for example, the submission of this information to a billing agent for processing claims or obtaining payment and/or submission of claims to insurers.

When you sign this consent document, you expressly agree that we can and will use and disclose your Personal Information to treat you, to obtain payment for our services, and to operate Bloom Behavioral Health Partners. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You also acknowledge, by your signature below, that you have received a copy of our HIPAA Notice of Privacy Practices.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES.

Patient Signature:_____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____

Print Name: _____

Bloom
Behavioral Health

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACYPRACTICES

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

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