Free Clinic of Simi Valley

Date_____

Minor Client Intake Packet

Name_____ Age_____ Date of Birth _____

Address_____ City_____Zip_____

Home Phone ( )_____ Work ( )_____ Cell/Pager( )_____

With whom does the child reside? Both Biological parents Shared Physical Custody Bio Mom Bio Dad

Is it O.K. to call you at home? _____ At work?_____ Cell? _____ May I identify myself/leave message? _____

Reason(s) for seeking therapy:_____

Who referred you to me? _____ May I thank them? Y N

Parents Marital Status (Circle) S M D W Sep How Long?_____ Previous Marriage(s)?_____

Is your child adopted Y N At what age?_____ Open Adoption Y N

Previous Counseling? Y N When_____ Duration_____Was it a good experience?_____

Have you or your child ever been hospitalized for psychological treatment?____Yes_____No_____
Who_____When?_____Where_____

Is your child currently under a physician's and/or psychiatrist's care?_____

M.D. & Phone_____

Medications Currently Taking (use back of page if needed)_____

Please indicate your (Parents) highest level of education:

Some High School_____ H.S. Diploma____ Some College_____ College____ Degree____ Graduate Degree_____

Parents Information:

Biological Mothers Name_____Age_____ Birthdate_____

Mothers Occupation_____ Employer_____ Address _____

Biological Fathers Name_____Age_____ Birthdate_____

Fathers Occupation_____ Employer_____ Address _____

Address (If different than above)_____

Home Phone ( )_____ Work ( )_____ Cell ( )_____

CHILDREN:

Name _____ Birthdate _____Name _____ Birthdate _____

Name _____ Birthdate _____Name _____ Birthdate _____

Name _____ Birthdate _____Name _____ Birthdate _____

OTHERS LIVING IN HOME: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY:

Name _____ Phone _____ Relationship _____

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Free Clinic of Simi Valley
Agreement for Psychotherapy Services

Client(s) Name(s):_____ Date:__

Because therapy often begins in a situation of considerable emotional difficulty, I have prepared these notes so that you will have an understanding of our basic agreement

The Process of Therapy

A therapy session typically lasts 45 - 50 minutes, beginning on the hour and ending at 10 - 15 minutes before the next. I encourage you and your child to "switch gears" before you arrive and take advantage of the entire session time.

Risks and Benefits: Participation in therapy can result in a number of benefits to you and your child, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on the part of the participants. Psychotherapy requires very active involvement, honesty and openness in order to change thoughts, feelings, and/or behavior. I will ask for your feedback and views on therapy as it progresses, and will expect you to respond openly and honestly.

During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in the experiencing of discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. As your child's therapist, I may challenge some assumptions or perceptions, or propose different ways of looking at, thinking about, or handling situations that can cause you or your child to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought your family to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. Although I certainly expect that psychotherapy will yield positive or intended results, there is no way to guarantee this.

Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. Their approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, play or expressive therapy, art therapy, somatic experience or EMDR, psychological testing or psycho-educational techniques.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of therapy, their possible risks, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If your child could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining these treatments, and will gladly do so.

Agreement for Psychotherapy Services

Client(s) Name(s): _____ Date:_____

Terminating Treatment: Termination from therapy is an important process which can be of benefit to clients and therapist. This is an important opportunity to reflect on progress, or lack of, and the process of where you are now and where you hope to be going. I encourage my clients to partake with me in this process of finding out what was helpful and what could have been more helpful. It is your right to terminate therapy at any time. However it is especially important for children to have an adequate time to say goodbye. I do request that you and your child come in to discuss leaving and any feelings that may be associated with the process. If you choose to terminate, I will be glad to provide referrals to qualified professionals. As your therapist, I have the right and duty to terminate therapy under the following circumstances: when I assess that treatment is no longer helpful or beneficial to your child, if I determine that another professional would better serve your needs, if you have not paid for the last two sessions (unless a special arrangement has been made), or if you have failed to show up for your last two sessions without the required 24 hour notice of cancellation. In all cases I will be happy to provide you with resources and referrals as necessary.

Child Care: There are no facilities for the supervision of children while you or your child are seeing their therapist. Please make arrangements for safe, reliable supervision of your children during counseling sessions.

Telephone and Emergency Procedures: If you need to contact me between sessions, please call the clinic at (805) 522-3733. Make an effort to call during clinic hours Monday – Friday 5PM to 8 PM. If you need to call at another time please leave a voice message. The system requires a touch tone phone. You may also reach me at: _____and I will respond at my earliest convenience. If an emergency arises, please indicate it clearly in your message. If you have not heard from me after a few hours, please call again (there are occasions where your page does not reach me due to technical error.) If there is a life-threatening emergency and you cannot reach me, please call 911 or go to the closest emergency room.

Your therapist's name is_____ Voice Mail Box #_____

Confidentiality: An important aspect of the therapeutic relationship is confidentiality. Knowing that I will keep communications private helps to make this a safe place for you and your child to explore, to learn and to grow. Please be aware that the only exceptions to confidentiality are: 1) when you have given written consent for me to share information, 2) when I am required to do so by law, as in cases of suspected child, elder or dependent abuse, or actual or potentially dangerous behavior toward yourself or others, 3) as required/allowed by HIPPA (please read the HIPPA form for further clarification of the privacy of your health information and records), and 4), because I am in training, I will be sharing information with my supervisors and other interns/trainees during supervision. In this way, you receive the benefit of several therapists working together for your best interests. I may also consult with Free Clinic Medical or Administrative staff as deemed necessary. I will meet with you regularly about your child's treatment but will need to maintain some degree of confidentially to promote emotional safety for your child to feel free to be honest. I welcome any questions you may have about the therapy process and practices, so please feel free to discuss these with me. I will meet with you regularly about your child's treatment but will need to maintain some degree of confidentially to promote emotional safety for your child to feel free to be honest.

Video and Audio Recording: Because I am in training and must be monitored by licensed therapists to help me provide you the best possible therapy, I will be video or audio taping your child's sessions from time to time. I will notify you in advance of the recording. I will protect your child's identity and destroy the tape after viewing. I will be playing the tape during my individual or group supervision sessions. By signing this agreement you release the Free Clinic of Simi Valley and me from any legal liability. Consent for use of video/audio tapes shall remain in effect until_____.

Agreement for Psychotherapy Services

Client(s) Name(s): _____ Date:_____

Financial Terms

Fees: The Free Clinic of Simi requests a donation for psychotherapy of $25 per 50 minute session. After we discuss this (on or before our first session), I will note any different arrangements here:_____

Cancellation and Missed Appointment Policy. Scheduled appointment times are reserved especially for you. We request at least a 24 hour notice for cancelled appointments. Please note that it is important for your child to attend sessions on a regular basis. Due to the importance of attendance and an overwhelming demand for psychotherapy services at the Free Clinic of Simi Valley, two consecutive missed appointments could result in termination of therapy. Please help us continue to provide the best service to our clients by honoring your appointment time. If your appointment is after 5 PM please check in with the receptionist in the main entrance. If your appointment is before 5 PM or on weekends go to the door on the left side of the building and ring the bell. Your therapist will greet you at your appointment time. Please do not ring the bell early. **Initial here:_____**

If there are specific phone numbers you WOULD like me to use to contact you, please note, and give me directions as to what I may and may not say, directly or in a message:

_____

_____

If there is a specific address, other than your home, that you WOULD like communication sent to, please state:

_____

If there are phone numbers and/or addresses on the intake form that you WOULD NOT like me to use, please state: _____

Consent for Treatment

This is to certify that I give my permission to the therapist listed above for treatment of my child. This treatment May include individual, family, or group therapy, and testing.

This treatment may include consultations with other associates including Educational Psychologists, Career Counselors, physicians, school staff, or nutritionists.

I understand the purpose of these procedures will be explained to me upon my request, and are outlined above in this document, and that they are subject to my agreement.

California State Law mandates the reporting of certain types of child abuse including physical abuse, sexual abuse, and neglect, emotional and psychological abuse.

All actual or suspected acts of child abuse will need to be reported to the appropriate agency. This treatment may also include referral to other appropriate State and County agencies for further treatment.

I have read the above and agree to contents. Initial Here_____

_____ _____

Parent/Client Signature **Date**

_____ _____

Parent/Client Signature **Date**

_____ _____

Therapist Signature **Date**

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Client Questionnaire

Client Name_____Date_____

Why are you here? Describe reasons for seeking help.

What help do you expect from therapy?

Is there anything from past history that may be related to the difficulties your child is experiencing now? (trauma, abuse, substance use, learning difficulties etc....)

On a scale of 1-10 with 1 being mild and 10 being severe, how would you rate the severity of your child's current difficulties?

Is your child depressed at this time? Yes____ No_____ Sometimes_____
How serious would the depression is? (Scale of 1-10) _____
Has your child had any suicidal thoughts? Yes_____ No_____
Has your child ever attempted suicide? Yes_____No_____
Any history of suicide attempts in family members? Yes_____ No_____
Who? _____
Whom have you presently consulted about your present problems?
_____
List your child's five worst fears: Worst fear first: 1)_____ 2)_____
3)_____ 4)_____ 5)_____
What do you consider your child's strengths?
_____
_____

Please check all of the following which are, or have been, problems for your child:

__ Anxiety	**__Loneliness**	**__Claustrophobia**	**__Parental Marital Problems**
__Shyness	**__Nightmares**	**__Bowel problems**	**__Lack of appetite**
__Tension	**__Overweight**	**__Can't have fun**	**__Can't keep a job**
__Tremors	**__Child abuse**	**__Hearing noises**	**__Stomach problems**
__Insomnia	**__Nail biting**	**__Money problems**	**__Can't concentrate**
__Dizziness	**__Underweight**	**__Suicidal ideas**	**__Lack of exercise**
__Headache	**__Can't decide**	**__Take sedatives**	**__Can't make friends**
__Parenting	**__Palpitations**	**__Fainting spells**	**__Don't like weekends**
__Tiredness	**__Feel panicky**	**__Unable to relax**	**__Bad home conditions**
__Alcohol use	**__Unemployment**	**__Memory problems**	**__Inferiority feelings**
__Drug use	**__Over-ambitious**	**__School problems**	**__Sexual problems**
__Depression	**__Seeing things**	**__Sexual assault**	**__Sexual abuse**
__Physical abuse	**__Eating disorder**	**__Sleeping trouble**	**__ADD (ADHD)**
__Fearful	**__Angry**	**__Head Injury**	**__Witness Family Violence**

Other problems:

Please describe your pregnancy with this child_____
_____

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Client Questionnaire (Continued)

Name_____ **Date**_____

Describe your emotional connection with your child in the first year_____
_____
_____

Describe your child's health in the first year_____
_____

Any separations? _____ **Please Describe**_____

Physical History- Check any that may apply, past or present:

__Heart problems	__Liver problems	__Shortness of breath
__Cancer	__Immune disease	__Hepatitis/jaundice
__Pain or pressure in chest	__Severe headaches	__Diabetes
__High blood pressure	__Head injury	__Tuberculosis
__Sexually transmitted disease	__Stroke	__Alcoholism
__Drug Abuse	__Epilepsy/convulsions	__Asthma
__Allergies	__Seizures	__Kidney problems
__Bedwetting/soiling	__PMS	__Traumatic Event –describe
__Pregnancy #___	__Abortion #___	

Family of Origin History (parents, siblings, grandparents, aunts, uncles)
Please circle any that apply:

Depression	Bipolar (manic/depression)	Eating disorder	Alcoholism
Violence	Child abuse/sexual abuse	Jail	Drug abuse
Anxiety	Attention deficit disorder	Trauma	Schizophrenia Gambling
Suicide	Pornography	School failure	

Alcohol or other substance use <u>in the family</u>. Please describe and use reverse side if necessary:

Please indicate <u>past</u> and <u>current</u> use .

Alcohol_____ **Amount**_____**Frequency**_____

Marijuana_____**Amount**_____**Frequency**_____

Cocaine_____ _____**Amount**_____**Frequency**_____

Methamphetamine ____**Amount**_____**Frequency**_____

Others_____

NOTICE OF PRIVACY OF PRACTICES
FACT SHEET

THIS NOTICE BRIEFLY DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE FREE CLINIC OF SIMI VALLEY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. (Protected health information is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.) PLEASE REVIEW THIS NOTICE CAREFULLY. ATTACHED IS A MORE COMPLETE DESCRIPTION OF THIS INFORMATION.
If you have any questions about this notice, please contact our COMPLIANCE COORDINATOR at 522-3733

We are required by law to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

For Treatment
For Payment
To Individuals Involved in Your Care or Payment for Your care
To Determine Treatment Alternatives
For Health-Related Benefits and Services
For Health Care Appointment Reminders
To Coroners or Medical Examiners
For National Security and Intelligence Activities
As Required By Law Enforcement
Military and Veterans
To Avert a Serious Threat the Health or Safety
To Workers Compensation
To Resolve or Prevent Public Health Risks
In You Are an Inmate
In Lawsuits and Disputes
For Health Oversight Activities

- You have the right to inspect and copy medical information that may be used to make decisions about your care.
- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the Free Clinic of Simi Valley; is not part of the information which you would be permitted to inspect id copy; or is accurate and complete.
- You have the right to request a list of the disclosures we made of medical information about you other that our own uses for treatment, payment and health care operations, as those functions are described above.
- You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, additional information may be needed to provide you emergency treatment.
- You have the right to request that we communicate with you about medical matters in a certain way or at certain location.
- You have the right to a paper copy of this notice.

We reserve the right to change this notice. Each time Free Clinic of Simi Valley services are initiated, we will offer you a copy of the current notice in effect. If you believe your privacy rights have been violated, you may file a complaint with the Free Clinic of Simi Valley or with the: Secretary of the Department of Health and Human Services. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission.

I have read this notice and have received a full copy of the Free Clinic of Simi Valley “Notice of Privacy Practices” which more fully explains these practices, lists examples and provides phone numbers for contact.

_____ _____
Client Signature Date

FREE CLINIC OF SIMI VALLEY

NOTICE TO CLIENTS

To be provided to the individual client before mental health services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable

or

to a parent or legal guardian when the client lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA) , (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, mental health or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (0)).

Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by the above Federal law.

[1] If the free clinic imposes charges based on a patient's ability to pay, this will negate the FTCA coverage of the volunteer(s) for the specific services for which the clinic received payment.

[2] A licensed or certified health care practitioner is an individual required to be licensed, registered, or certified by the State, Commonwealth or territory in which a Free Clinic is located. These individuals include, but are not limited to, physicians, dentists, registered nurses, and others required to be licensed, registered, or certified (e.g., laboratory technicians, social workers, mental health workers, medical assistants, licensed practical nurses, dental hygienists, and nutritionists). The definition will vary dependent upon legal jurisdiction.

[3] Examples of cases in which a free clinic could grant temporary privileges to a LIP in order to meet important patient care needs for a limited period of time include:

1. A current LIP becomes ill or takes a leave of absence, and another LIP is needed to cover patient care until the current LIP returns; or
2. A current LIP does not have the necessary skills to provide needed patient care.

Acknowledgement

_____	_____	_____
Patient Signature	Patient Name	Date

FREE CLINIC OF SIMI VALLEY
Parent Questionnaire #1

Client Name_____ Parent's Name_____ Date_____

Answer the following questions. Then check the accuracy of your answers with your child.

1. What is your child's favorite game? _____

2. What is the name of your child's closest friend? _____

3. What is your child's favorite sport? _____

4. What movie did your child last see (not on TV)? _____

5. What is your child's favorite main dish? _____

6. What is your child's favorite musical group or singer? _____

7. What subject does your child like most in school? _____

8. Where does your child go when he wants to be alone? _____

9. What pet would your child most want to have? _____

10. What is your child's nickname among friends? _____

11. Which household chore does you child least like to do? _____

12. Name the last present your child gave to you. _____

13. What was the last nice thing that your child did for you that really surprised you?
_____

14. Name two qualities in your child that you are proud of. _____

15. What is your child's favorite television show? _____

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FREE CLINIC OF SIMI VALLEY
Parent Questionnaire #2

Client Name_____ Parent's Name_____ Date_____

Parents: Please take some time and answer each question with as much detail as you can. Be specific. This will help me in making a complete and thorough assessment.

Basic Thoughts/Feelings about your child:

1. What are your child's interests?
2. What types of activities is he/she involved in?
3. What are your child's strengths?
4. Areas of difficulties?
5. List some of your child's characteristics/qualities that you admire.
6. Describe some aspects of your child that you'd like them to change.
7. What are some of your hopes and dreams for your child?

Past/Present History:

1. What is your child's age?
2. What school does he/she attend and grade level?
3. Who is your child's pediatrician and when was their last physical exam?
4. Does your child have any serious illnesses; allergies; previous surgeries?
5. Family Medical History (surgeries; illnesses; hospitalizations)
6. Is there a family history of alcoholism, mental illness or violence (including suicide, depression, abuse, etc.)
7. Please specify all medications your child is currently taking or has taken in the past.

Current Behaviors:

1. Describe your child's primary difficulties/your main concerns regarding your child.
2. Was the child seen in therapy in the past? If so, with whom and for how long?

FREE CLINIC OF SIMI VALLEY
Parent Questionnaire #2

Client Name_____ Parent's Name_____ Date_____

3. Describe your child's relationship with each parent

4. What types of consequences are implemented at home, for what types of behaviors, and do both parents work together in this respect?

5. What losses, if any, has your child experienced (i.e. death of a family member, relative, friend or pet; move to new neighborhood; separation/divorce; etc.)

6. List your child's worst fears, concerns and/or worries.

7. Describe your child's academic performance at school:

8. Does your child exhibit behavioral difficulties at school (i.e. inability to sit still; difficulty concentrating; noncompliance; etc.)

9. How well does your child interact with their peers? Any specific challenges?

10. Is your child able to maintain age-appropriate friendships, or do they prefer to do things by themselves?

11. Describe your child's TV and/or Video/Computer habits.

12. Describe your child's eating habits/diet. Please include snacking, meals, types of food and frequency.

13. Does your child have difficulty falling asleep at night; wake up in the middle of the night or early in the morning?

14. How would you describe your child's behavior at home? At school? Away from home and school?

15. Does your child engage in "risk-taking" behavior (i.e., riding scooter down steep hills, etc.)

16. Has your child ever run away from home, or threatened to do so? Give specifics.

17. Are there any difficulties with bed-wetting, or having frequent accidents during the day?

FREE CLINIC OF SIMI VALLEY
Parent Questionnaire #2

Client Name_____ Parent's Name_____ Date_____

18. Does your child cry easily or gets his feelings hurt more often than other children his/her same age?

19. Is your child overly anxious and/or fearful?

20. Does your child engage in excessive lying or stealing?

21. Has your child ever destroyed property (things belonging to him/her or others?)

22. Is your child aggressive toward other children, animals, and/or adults? Please describe.

23. Does your child exhibit "self-destructive" behavior (hitting, biting self; head-banging?)

24. Does your child have frequent headaches, stomach pains, nausea or other physical ailments? If so please describe.

25. Are your child's emotions strong and change quickly and dramatically? Please describe.

26. Does your child argue or speak rudely toward others?

27. Does your child seem to have difficulty with not being able to get certain thoughts, worries or concerns out of their minds?

28. Is your child tense and easily startled (jumpy?)

29. Does your child have difficulties with transitions or changes in their daily routines/schedules?

30. Do you believe your child has difficulty trusting others?

31. Does your child exhibit defiant/argumentative behavior?

32. How often does your child complain about rules, expectations and responsibilities?

33. Does your child get easily frustrated/agitated or annoyed over minor disturbances?

34. Has your child ever exhibited suicidal ideations and/or expressed that "they would be better off dead?"

35. Does your child have frequent nightmares and/or night terrors?

FREE CLINIC OF SIMI VALLEY
Parent Questionnaire #2

Client Name_____ Parent's Name_____ Date_____

36. On a scale from 0-10 (with 10 being highest), how angry can your child get? For what reasons?

37. Do you find that your child gets into trouble more often when they are bored?

38. Does your child act impulsively (without thinking first?)

39. Has your child ever expressed a belief that they have no friends and/or that no one likes them?

40. Does your child pick, scratch or bite things (fingernails, hair, clothing, skin?)

41. Is your child overly fearful and/or cautious (of new situations; new people or places; going to school?)

42. Do you find your child daydreaming oftentimes during the day?

43. Does your child deny mistakes or blame others for their own actions?

44. Does your child need to continue doing something until "it's perfect?"

45. Is your child unable to stop an activity after being given 2-3 prompts?

46. Would you describe your child as "being a bully?"

47. Do your child's feelings get easily hurt?

48. Is your child excessively clingy; needy; seeking attention?

49. Does your child get easily frustrated with themselves and/or their efforts?

50. When at home, does your child choose to spend time alone?

51. How often does your child interact with peers his/her own age?