A.T.L. PSYCHOTHERAPY
& CONSULTING SERVICES
Sandtown Professional Park
5835 Campbellton Rd. SW, suite 102
ATLANTA, GA 30331
(404) 941-7326 (office) (404) 941-7556 (fax)

Child/Adolescent Intake Form Today's Date

Identifying Information		
Child's Full Name:		
Child's Date of Birth:		Age:
Home Address:		
Cell phone number:		
Home phone number:		
Child's Legal Guardian:		
Person(s) completing this form:		
Disability Status:		
Gender Identity:		
Sexual Orientation:		
Racial/ethnic identities:		
Religious/spiritual traditions or identity:		
Other ways you identify your child and consider important:		

Family Information		
Please Circle One: Mother/Guardian	Name:	Age:
Best phone number:	Other phone number:	
Address:		
Email:	Occupation:	
Employer:	Location:	

Please Circle One: Father/Guardian	Name:	Age:
Best phone number:	Other phone number:	
Address:		
Email:	Occupation:	
Employer:	Location:	

Parents are currently:	☐Married ☐Divorced ☐Separated ☐Remarried to others ☐Never married
Patient lives with:	☐Mother ☐Father ☐Relative ☐Guardian Other:_____
Who has legal custody* of this child?	☐Mother ☐Father ☐Both/shared ☐Relative Guardian Other:_____ *Please bring custody or court papers to the first appointment if they exist.

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?	
Name:	Relationship:_____ Phone:_____
Address:	
Does the child have stepparents? ☐Yes ☐No	
If yes, please provide name and phone number:	
Name:	
Phone Number:	
How frequently does this child see his/her grandparents?	
Has the family recently experienced any unusual or stressful events? ☐No ☐Yes	
If yes, explain:	

Referral

Who gave you my name to call?	
Name:	Phone:
Relationship:	
How did this person explain how I might be of help to you?	
Is this person's relationship with your Personal or Professional? (Circle one)	
If professional, may I have your permission to thank this person for the referral?☐ Yes☐No	
Should I consult with this person about the referral? ☐Yes ☐No	

Presenting Problem	
Why are you seeking this evaluation or treatment?	
When did these problems begin?	
What are your goals for this evaluation or treatment?	

Please select any of the following areas of concern for your child, either past or present

☐Alcohol/Drug Abuse	☐Medical Issues	☐Depressed Mood	☐Body Image
☐Homicidal thoughts	☐Aggression	☐Legal Involvement	☐Physical Complaints
☐Distractibility	☐Bedwetting	☐Problems Finishing work	☐Obsessions/Compulsions
☐Poor Concentration	☐Soiling	☐Suicidal Thoughts/Acts	☐Binge Eating
☐Sleeping Problems	☐Helplessness	☐Hallucinations/Delusions	☐Lying
☐Motor/Vocal Ties	☐Shyness	☐Bullying/Teasing	☐Fighting
☐Hyperactivity	☐Impulse Control Problems	☐Confused Often	☐Stealing
☐Oppositional	☐Low Self-Esteem	☐Nightmares	☐Fire Setting
☐Irritability	☐Food issues	☐Family Problems	☐Trauma

☐Sexual Abuse	☐Runaway	☐Excessive Worrying	☐Anger management
☐Physical Abuse/Neglect	☐Witness Domestic Violence	☐Separation Anxiety	☐School Problems
☐Decreased Attention	☐Cruelty to Animals	☐Self-Harming Behavior	☐Parental Separation/Divorce

Homes/Residences				
Child's age when moved	Location	Lived with whom?	Reason for moving	Problems there

Please list anyone living in the household

Name	Age	Gender	Live at home	Relationship with child

Did the mother receive prenatal medical care?	☐No☐Yes
If yes, what kind?	
Length of pregnancy:	
Did the mother experience any emotional or medical difficulties during the pregnancy?	☐No☐Yes
If yes, explain:	

Length of Labor: Hours	Apgar scores:
Birth weight: lbs. oz.	Length: inches

Development		
Was this child breast-fed or bottle fed?	Age weaned:	
Did the child experience any of the following problems during infancy or toddlerhood?		
Colic	☐No	☐Yes

Excessive crying	☐No	☐Yes
Delayed language development	☐No	☐Yes
Unclear speech	☐No	☐Yes
Eating Problems	☐No	☐Yes
Delayed fine motor skills	☐No	☐Yes
Delayed gross motor skills	☐No	☐Yes

At what approximate age did your child begin exhibiting the following behaviors?	
Crawled:	Sat alone:
Walked independently:	Spoke first words:
Spoke in sentences:	Was toilet trained:
For an adolescent, please indicate the following:	
Age at onset of puberty:	Age at first menstruation (for a girl):
What hand does your child use for writing? Eating?	
Throwing?	Other?
Has your child been the victim of abuse?	☐No☐ Yes
If yes, explain:	

Medical History

Name of child's primary care physician?	
Address:	
Phone:	
Date of most recent physical exam:	Results:
Date of most recent dental exam:	Results:
Date of most recent vision exam:	Results:
Date of most recent hearing exam:	Results:
Has the child experienced any of the following medical problems? If yes, please explain.	
Frequent colds	☐No ☐ Yes
Frequent ear infections	☐No ☐ Yes
Asthma	☐No ☐ Yes

Gastrointestinal problems	☐No ☐ Yes
Muscle pain	☐No ☐ Yes
Skin problems	☐No ☐ Yes
Repetitive behaviors	☐No ☐ Yes
Allergies	☐No ☐ Yes
Vision problems	☐No ☐ Yes
Does your child wear glasses?	☐No ☐ Yes
Hearing problems	☐No ☐ Yes
Cerebral palsy	☐No ☐ Yes
Lead poisoning	☐No ☐ Yes
Seizures	☐No ☐ Yes
Congenital problems	☐No ☐ Yes
Please list any other health concerns:	

Medication

Is your child currently taking any kind of medication? ☐No ☐Yes

Name: Dose: Reason:

_____

_____

Is your child experiencing any side effects from the medication?

Alcohol/Drug Use/Legal Involvement

Does your child use alcohol or drugs?	☐No ☐ Yes
If yes, explain:	
Is your child involved with any current legal difficulties? If yes, please explain.	

Previous Evaluations

Has your child ever had any of the following evaluations? If yes, please indicate name of the examiner, date of exam, and reason for exam.

Psychological or psychiatric evaluation:	☐No ☐ Yes
If yes, name of evaluator:	Date of valuation:
Reason for evaluation:	
Neuropsychological evaluation:	☐No ☐ Yes
If yes, name of evaluator:	
Reason for evaluation:	
Neurological evaluation:	☐No ☐ Yes
If yes, name of evaluator:	
Reason for evaluation:	

Treatment History

Has your child ever received counseling or psychiatric treatment? ☐Yes☐ No

If yes, indicate dates, name of treating professional, reason for treatment, and effectiveness of treatment:

Family's Health

Mother's present health:

Father's present health:

Has anyone in your family experienced a mental, psychological, or academic problem, such as mental retardation, learning disabilities, schizophrenia, depression, epilepsy, or bipolar disorder? ☐No☐ Yes

If yes, explain:

Social History

How does your child relate to other children?

Does your child prefer to play with younger or older children? ☐No ☐Yes

If yes, indicate which (younger or older) and explain:

Does your child have a best friend? ☐No☐ Yes

How many friends does your child have?

Recreational Interests

Does your child participate in sports or recreational activities outside of school? ☐No☐ Yes

If yes, describe:

What does your child like to do in his/her free time?

Have the child's interests in these activities changed recently? ☐No☐ Yes

If yes, please explain:

What are your family's favorite activities?

Behavioral Symptoms

Does your child have difficulty with any of the following problems? If yes, please explain.

Has trouble meeting new people; is shy or withdrawn	☐No ☐ Yes
Is overly anxious	☐No ☐ Yes
Seems sad or depressed	☐No ☐ Yes
Has thought of suicide	☐No ☐ Yes
Refuses to comply with adults' requests or violates parental rules	☐No ☐ Yes
Has conduct problems	☐No ☐ Yes
Is physically cruel to other people or animals	☐No ☐ Yes
Is inattentive	☐No ☐ Yes
Problems concentrating	☐No ☐ Yes
Is restless	☐No ☐ Yes
Makes careless mistakes	☐No ☐ Yes
Has trouble playing quietly	☐No ☐ Yes
Has frequent mood shifts	☐No ☐ Yes
Frustrates easily	☐No ☐ Yes
Has difficulty managing anger	☐No ☐ Yes
Has eating problems	☐No ☐ Yes

Has fears/phobias	☐No ☐ Yes
Has hallucinations	☐No ☐ Yes
Has experienced trauma	☐No ☐ Yes
Has your child ever experienced difficulty with the law?	☐No ☐ Yes
If yes, explain:	

Educational Status and History

Current Status

Name of current school:	Grade:
Type of school: Private Public Home-schooled Other:	
Teacher(s):	
School address:	
School phone number:	
Does your child currently receive any special education services?☐ No☐ Yes	
If yes, please specify:	
What grades does the child currently receive?	
Is this a change from previous year? ☐No ☐Yes	
If yes, explain:	

School History

Preschool: At what age?	For how many days/hours?
Any problems? ☐No ☐ Yes. If yes, describe:	
Did the child have difficulty or receive any special education services in any of the following grades? If so, please explain.	
Kindergarten	☐No ☐ Yes
Grades 1-3	☐No ☐ Yes
Grades 4-6	☐No ☐ Yes
Grades 7-8	☐No ☐ Yes
High School	☐No ☐ Yes

Does your child dislike going to school?	☐No ☐ Yes
If yes, why?	
What are your child's favorite subjects?	
What are your child's least favorite subjects?	
What is your child's approach to her/his school work (disorganized/organized, irresponsible/responsible, etc.)?	

Work History

Does your child have a job, or is your child involved in a vocational program? ☐No ☐Yes	
If yes, who is the child's current employer?	
Child's position:	Hours worked per week:

Confidentiality

In general, the privacy of all communications between a patient and psychologist is protected by law, and your therapist can only release information about your work to others with your written permission. However, there are a few exceptions. If your therapist has reason to believe that a child, elderly person, or disabled person is being abused, they must file a report with the appropriate state agency. If your therapist becomes aware of an immediate threat of harm to a particular individual, they would be required to take protective actions that might include notifying the potential victim, contacting the police, contacting family members, or seeking hospitalizations. If a patient threatens to harm himself/herself, your therapist may be obligated to seek hospitalizations for him/her to contact family members or others who can provide protection. These situations have rarely occurred in our practice. If a similar situation occurs, your therapist will make every effort to fully discuss it with you before taking any action.

Your therapist may also occasionally find it helpful or even necessary to consult other professionals about your case. During a consultation, every effort will be made to avoid revealing your identity. The consultant is also legally bound to keep the information confidential. If you do not object, you will not be told about these consultations unless your therapist feels it is important to your work together. The laws and standards of the psychological profession require that treatment records are kept. You are entitled to receive a copy of your records, or your therapist can prepare a summary for you. However, since these are professional records, they can be misinterpreted by untrained readers. If you wish to see your records, we recommend that you review then in your therapist's presence so that they can discuss the contents with you. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

Records can be released to a third party with your written consent. This might include for example, release of information to another treatment provider or an insurance carrier per your request. Please note, however, that your therapist cannot be responsible for the confidentiality of disposition of records released to a third party once in the hands of that third party. Once you are given a copy of your report, you are responsible for its confidentiality. You will need to be careful of who receives a copy of the report and explore how they will use and store the information provided. You are encouraged to keep the report in a safe place to ensure its protection and privacy. If you do not sign this form agreeing to our privacy practices, we cannot treat you, because we need to use you PHI to evaluate, diagnose, and treat you.

Contacting Therapist

Our telephone number is (404) 941-7326 and our email address is atlinfo@atlpsychology.com. Although your therapist is not immediately available to take calls, you are welcome to schedule a brief phone consultation to discuss the issue(s) you may have. Email is always the best form of communication. Your therapist will make every effort to return your email within 48 hours, with the exception of weekends and holidays. If your therapist is out of the office for extended time, they will leave the name of a colleague who may be contacted if necessary.

In an emergency, you can try to contact your therapist at out office number. If you are unable to reach your therapist and feel that you cannot wait for a return call or email, please call 911 or go to your local emergency room and ask for the physician on call.

I have thoroughly read over the confidentiality and contact information.

_____

Signature of client or personal representative

I have completed these forms to the best of my ability

_____

Signature of client or personal representative

Paperwork Fee Policy

We require a minimum of three office visits prior to any paperwork being filled out for clients. This includes, but is not limited to, FMLA, SSI disability, and treatment progress reports. There will be a **$25.00 fee** at the time of the request for forms to be filled out and completed.

*Please note that all requests will have a two-week turnaround time.

_____

Responsible Party- Print name

_____

Responsible Party- Signature

_____

Date

Credit Card Authorization

I authorize **ATL Psychotherapy & Consulting Services** to charge my credit card for services rendered, no show fees, and late cancellation fees. This information is stored in a secure system. This information will be destroyed upon termination of counseling and balance is paid in full.

_____

Responsible Party- Signature

_____

Date

Authorization for Release of Information

Client's Name _____
Date of Birth:_____

I hereby authorize **ATL Psychotherapy & Consulting Services** to release, obtain, or exchange information about my psychological treatment, either verbally or in writing, to the following agency or individual:

Name: _____
Address:_____
_____
Phone: _____ Fax: _____

Such information may include records of my psychological evaluation and treatment. The purpose of this release is:

I acknowledge that this release may be revoked in writing at any time, and that otherwise it is valid until termination of treatment.

I hereby release ATL Psychotherapy & Consulting Services from any and all liabilities, responsibilities, damages, claims, or legal actions that might arise from the release of the information authorized above. I also release ATL Psychotherapy & Consulting Services from liability or responsibility for the disposition of these records once in the hands of the person or agency named above.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

This information is released specifically to you from records that are legally protected. You are prohibited from further releasing this information to any other party without specific written consent of the person to whom it pertains. The use and disclosure of information contained in this record is restricted by the Health Insurance Portability and Accountability Act of 1996 and is protected under the Privacy Act of 1974.

_____ _____
Signature of Client (or legal guardian) Date