PATHWAYS
COUNSELING CENTER

13105 W Bluemound Rd, Suite 100
Brookfield, WI 53005
P (262) 641-9790
F (262) 641-9791

INTAKE FORM – CHILD/ADOLESCENT

INTAKE DATE:_____

CLIENT: LEGAL NAME_____ SS#:_____

PREFERRED NAME, if different:_____ BIRTH DATE:_____

CAREGIVER'S NAME:_____

ADDRESS:_____ CITY:_____STATE_____ZIP_____

PHONE: H (____)_____W (____)_____ CELL (____)_____

Is it okay to call the numbers above? ☐ YES ☐NO Is it okay to leave a voicemail? ☐ YES ☐NO

EMERGENCY CONTACT (Name and Phone):_____

RELATIONSHIP STATUS: ☐ Single ☐Married ☐Domestic-Partnership ☐Divorced

GENDER:_____

REFERRAL SOURCE: ☐ Another Professional ☐ Existing Patient ☐ Website/Online ☐Friend/Family

☐ Other:_____

PRIMARY INSURANCE COMPANY INFORMATION

CARD HOLDER'S NAME:_____ BIRTH DATE: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY NAME:_____ PHONE: _____

MEMBER ID#_____ GROUP#_____EFFECTIVE DATE: _____

CARD HOLDER'S EMPLOYER:_____

EXCLUSIONS: ☐ **90832 (30 min.)** ☐ **90834 (45 min.)** ☐ **90837 (60 min.)** ☐**90853 (Group)**

SECONDARY INSURANCE COMPANY INFORMATION

CARD HOLDER'S NAME:_____ BIRTH DATE: _____

INSURANCE COMPANY NAME:_____ PHONE: _____

MEMBER ID#_____ GROUP#_____EFFECTIVE DATE: _____

*****************PLEASE READ AND SIGN BELOW******************

INSURED/CLIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize **payment** of any medical benefits to Pathways Counseling Center. I also understand that I am responsible for my bill. I authorize **release** of any medical or other information necessary to process this claim. I permit a copy of these signatures to be used in place of the originals.

_____

SIGN DATE

Office Use Only: Diagnosis (ICD-10 CODE): _____ **THERAPIST:**_____

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Acknowledgment of Notice of Privacy Practices

Patient/Client Name:_____

DOB: _____

I hereby acknowledge that I have been given an opportunity to read a copy of Pathways Counseling Center's Notice of Privacy Practices (laminated, two-sided Notice). I understand that if I have any questions regarding the Notice or my privacy rights, I can contact David Bedrin or Lynn Dusold at Pathways Counseling Center, 13015 W. Bluemound Road, Suite 100, Brookfield, WI 53005.

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member Date

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Consent for Transmission of Protected Health Information by Non-Secure Means

I, _____ AUTHORIZE _____
(Name of Client) (Name of Clinician)

TO USE THE FOLLOWING NON-SECURE MEDIA:

☐ Unsecured email
☐ SMS text message (i.e. traditional text messaging) or other type of "text message"
☐ Other media: Describe:_____

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

☐ Information related to the scheduling of meetings or other appointments
☐ Information related to billing and payment
☐ Completed forms, including forms that may contain sensitive, confidential information
☐ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
☐ Other information Describe: _____

TERMINATION

☐ This authorization will terminate _____ days after the date listed below, OR
☐ This authorization will terminate when the following event occurs:_____

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____
Signature of minor age 14 years or older Date

_____ _____
Signature of legal representative Date

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Consent for CHILD/ADOLESCENT Admission For Mental Health Evaluation and/or Treatment

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Pathways Counseling Center. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment
2. A psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed will conduct the evaluation or treatment. Treatment will be conducted within th boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Therapy.
3. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.
4. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. I have received a fee schedule pertaining to my therapist.
5. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidentia record at Pathways Counseling Center, and I consent to disclosure for use by Pathways Counseling Center staff for the purpose of continuity of my child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to her/himself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.
6. **Discharge Policy:** There are circumstances under which my child may be involuntarily discharged. I have read and understand the discharge policy of the clinic.
7. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.
8. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____
Signature of minor age 14 years or older Date

_____ _____
Signature of legal representative Date

_____ _____
Signature of witness Date

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Patient Bill of Rights

Please note the framed poster in the lobby regarding Patient Rights. Every patient at Pathways Counseling Center has the right to:

1. Be treated fairly regardless of race, national origin, sex, gender, age, religion, disability, or sexual orientation.
2. Receive prompt and adequate treatment.
3. Participate in their treatment planning.
4. Be informed of their treatment and care, including alternatives to and possible side effects of treatment.
5. Refuse treatment and medications unless court-ordered.
6. Be free from unnecessary or excessive medications.
7. Be treated with dignity and respect by all staff.
8. Be informed of their rights.
9. Be informed of any costs of their care.
10. Refuse drastic treatment measures.
11. Not to be filmed or taped without their consent.
12. File complaints about violations of their rights. If you feel your rights have been violated, you may:
    a. Discuss the matter with staff about any concerns. However, you do not have to do this before filing a formal complaint.
    b. If you want to file a written complaint, you may use the "Client Rights Grievance Form" available from the receptionist.
13. Be free from any retribution for filing complaints.

Rights regarding Record Privacy and Access:

1. Staff must keep patient information confidential.
2. Records cannot be released without patient consent with some exceptions.
3. Patients may see their records.
4. During treatment, access may be limited if the risks outweigh the benefits.
5. Patients may challenge the accuracy, completeness, timeliness or relevance of entries in their records.

_____ _____

Signature of minor age 14 years or older Date

_____ _____

Signature of legal representative Date

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Child/Adolescent Pre-Treatment Questionnaire

To better assess if we can meet your family's needs, please fill out as completely as you can and bring with you to your first therapy appointment. Use additional sheets of paper as needed. The information you provide is confidential and protected by law. We look forward to meeting you.

Date Completed:_____

Name: _____ Parent/Guardian's Name: _____

1. Gender: _____ 2. Age: ___ Years 3. School: _____ Grade: _____

4. Ethnicity:_____ 5. Religion_____

6. Please list any long periods of time your child/teen has been out of school for any reason including major illness, home schooling, expulsion, etc.

_____

7. Child/teen lives with:

Name	Gender	Age	Relationship?
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

8. If child/teen is not living with one or both birth parents, what is the reason?_____

_____

9. Is your child/teen currently under a physician's care? Yes No Date of last physical exam:_____

List any physicians, **current medical conditions**, medications, and dosage (Add on the back if needed):

Condition	Medication	Dosage	Physician
_____			
_____			
_____			
_____			

10. Has your child received prior counseling or related services? (Circle one) Yes No

Name of therapist: ____________________________ Where: ____

Length of treatment: ______________mos./years How long ago? __________ mos./years ago

Problem(s) treated:____

Outcome: (circle one): 1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

Name of therapist: ____________________________ Where: ____

Length of treatment: ______________mos./years How long ago? __________ mos./years ago

Problem(s) treated:____

Outcome: (circle one): 1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

Name of therapist: ____________________________ Where: ____

Length of treatment: ______________mos./years How long ago? __________ mos./years ago

Problem(s) treated:____

Outcome: (circle one): 1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

11. When thinking about your child (or your self if you are the patient), do you/they have past or current experiences of abuse of any kind, including physical, emotional, verbal, or sexual? Please share below or with your therapist.

____

____

____

____

12. Please describe **current** substance use/abuse in the chart below. Please mark N/A if not applicable.

	Typical Frequency of Use In Past 6 Months					**Time of Last Use**		
	Daily	1-6 Times/ Week	Week-end Use Only	Few Times A Month	Once a Month or Less	Within Past Week	Within Past Month	Over 1 Month Ago
Alcohol								
Marijuana								
Cocaine (Powder, Crack)								
Amphetamines (Crystal Meth)								
Sedatives								
Minor Tranquilizers (Valium)								
Hallucinogens								
Barbiturates								
Heroin								
Other Opiates/Narcotics								
Inhalants								
Nicotine (Cigs, Vape)								
Caffeine								
Other: _____								

13. In general, how much of a problem do you think your child has with the following?

	1= least important				5= most important
	1	2	3	4	5
Family member wants me here					
Family problems					
Getting into trouble					
Getting along with his/her mother					
Getting along with his/her father					
Arguing with parent(s)					
Trouble following directions					
Communication problems					

(Continued) In general, how much of a problem do you think your child has with the following?					
	1= least important				5= most important
	1	2	3	4	5
Getting along with adults other than his/her caregivers					
Getting involved in activities like sports or hobbies					
Feel alone/trouble making friends					
Sexual orientation questions					
Gender Identity questions					
Having fun					
Getting along with his/her brothers or sisters					
Arguing with brothers/sisters					
Getting along with other children his/her age					
Trouble staying organized					
Trouble concentrating					
Difficulty with loss or death					
Trouble controlling impulses					
Problematic or too much anger					
Learning/memory problems					
Abuse (physical/sexual/emotional/verbal)					
Trauma other than abuse (natural disaster, accident, crime witness, etc.)					
Feeling unhappy or sad					
Feeling nervous or worried					
Depression or anxiety					
Thinking of hurting myself or someone else					
His/her behavior at school (or at work)					
Getting in trouble at school					
Learning his/her schoolwork (or doing his/her job) problems					

14. How much has your child's behavior caused:

	1= a little				5= a lot
	1	2	3	4	5
Interruption of personal time?					
Disruption of family routines?					
Any family member having to do without things?					
Any family member to suffer negative mental or physical health?					
Financial strain for the family?					
Less attention paid to any family member because of attention given to your child?					
Disruption or upset relationships within your family?					
Disruption of family's social activities?					
You to miss work or neglect duties?					

15. Were there any difficulties with the pregnancy, birth, or early childhood of your child? If so, please explain.

_____

16. What questions do you hope will be answered? _____

_____

17. Is there anything else you want the therapist or counselor to know before the first session? _____

_____

18. Who referred you to Pathways Counseling Center?_____

19. To get a better understanding of your child's symptoms, please complete the table below and bring to the first therapy appointment. Over the lasts 2 weeks, how often has your child been bothered by the following symptoms?

	Never	Several days	More than half the days	Daily
Sadness, hopelessness, feeling down				
Poor appetite or overeating; weight loss or gain				
Loss of interest or pleasure in doing things				
Fatigue or loss of energy				
Feeling bad about themself – that they are a failure or have let themselves or your family down				
Trouble concentrating, making simple decisions				
Thoughts of death or suicide				
Trouble falling or staying asleep, restless and unsatisfying sleep, or sleeping too much				

	Never	Several days	More than half the days	Daily
Restlessness, feeling keyed-up, or on edge				
Being easily tired				
Problems concentrating or mind goes blank				
Irritability				
Muscle tension				
Trouble falling or staying asleep, or restless and unsatisfying sleep				
	Never	Several days	More than half the days	Daily
An intense and persistent fear of a social situation in which people might judge them				
Fear that they will be humiliated by their actions				
Fear that people will notice that they are blushing, sweating, trembling, or showing other signs of anxiety				
Knowing that their fear is excessive or unreasonable				

Please provide any other information that you feel is important for the therapist to know:

_____

_____

_____

_____

Signature: _____ Date: _____