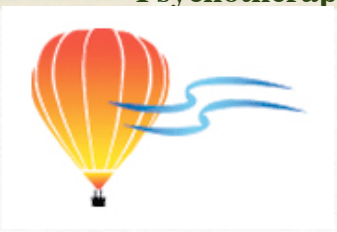
CATHRYN L. LEFF, LMFT

Psychotherapy Counseling Services for Couples, Adolescents and Children



CHILD & ADOLESCENT DEVELOPMENTAL HISTORY INTAKE FORM

Parents or Guardians: Please fill out one form per child

This information is private and confidential, as are all of our sessions (see privacy policy). Please complete as much of this form as you can.

PATIENT NAME: _____

MALE/FEMALE:_____TODAY'S DATE:_____

DATE OF BIRTH: _____

CITY: _____ STATE: _____

CUSTODIAL PARENT HOME ADDRESS:

_____

CITY:_____

STATE: _____ ZIP:_____

E-MAIL: _____

TELEPHONE: H: _____ W: _____

CELL:_____

OTHER_____

OCCUPATION:_____

BUSINESS TELEPHONE :_____

NON-CUSTODIAL PARENT HOME ADDRESS (if applicable):
_____

CITY:_____

STATE: _____ ZIP:_____

E-MAIL: _____

TELEPHONE: H: _____ W: _____

CELL:_____

SOCIAL SECURITY #:_____

OCCUPATION:_____

BUSINESS TELEPHONE :_____

PARENTS' STATUS (please circle): single, married, separated, divorced, widow(er)

(If Applicable) Live-in partner CHILD'S SIBLINGS (name and age):
_____

PATIENT'S MEDICAL DOCTOR

Name: _____ Phone: _____

RESPONSIBLE PARTY BILLING

ADDRESS:_____
CITY:_____

STATE: _____ ZIP:_____

E-MAIL: _____

TELEPHONE: H: _____ W: _____

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CELL:_____

OTHER_____

REFERRAL SOURCE:

_____

PATIENT 'S RESIDENCE – please circle:
Biological parent's home -Relative's home -Foster Home -Adoptive Home

Full term: Y N Complications at birth:

_____

_____

FAMILY STRUCTURE WHEN CLIENT WAS BORN

_____

_____

MILESTONES – Please indicate age:

Sat-up: _____ Crawled: _____ Walked: _____ Talked: _____
Toilet trained: _____

DESCRIBE DELAYS OR COMPLICATIONS IN ANY OF THESE AREAS:_____

_____

_____

DAYCARE OR PRE-SCHOOL? Y N AGE CHILD STARTED: _____
COMMENTS:

_____

_____

_____

_____

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WHO WAS/WERE THE CHILD'S PRIMARY CAREGIVER(S) FROM BIRTH TO 3 YEARS?

_____
_____
_____
_____

FAMILY HISTORY (include births, divorce, losses, transitions, remarriage, illness, moves, etc.)

_____
_____
_____
_____
_____
_____
_____

ANY MAJOR ILLNESS/SURGERIES?: Y N AGES:

_____

PLEASE DESCRIBE THE ILLNESS/SURGERIES:

_____
_____
_____
_____
_____

HAS THE CHILD EVER BEEN ILL OR ON MEDICATION(S)?
PLEASE DESCRIBE ILLNESSES/MEDICATION(S):

_____
_____
_____
_____

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ANY PSYCHIATRIC ILLNESS/HOSPITALIZATIONS? Y N
AGES:_____
_____
_____
_____
_____

ANY TRAUMATIC EVENT(S)?: Y N AGES: _____
PLEASE DESCRIBE:
_____
_____
_____
_____
_____

ANY INVOLVEMENT WITH CHILD PROTECTIVE SERVICES? Y N
AGES:_____
_____
_____
_____

ANY SUBSTANCE USE/ABUSE/DEPENDENCE? Y N

AGES:_____

PLEASE LIST NAMES/AMOUNTS:
_____
_____
_____

HISTORY OF COUNSELING: Y N

AGE(S):_____

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PLEASE CIRCLE TYPE OF TREATMENT:

Family-Individual- Group -School -Alateen -Day treatment -Hospital- Other

NAME OF PRIOR THERAPIST(S) AND REASON FOR TREATMENT:

_____

_____

_____

WOULD YOU LIKE ME TO CONTACT THEM? Y N

SUBSTANCE ABUSE TREATMENT: Y N AGE(S):

_____

PLEASE LIST FACILITY AND DATES:

_____

_____

_____

SCHOOL: _____ GRADE: _____

PLEASE DESCRIBE YOUR CHILD/TEEN'S OVERALL SCHOOL EXPERIENCES, INCLUDING TYPICAL GRADES, SOCIALIZATION, TYPE OF CLASSES –SPECIAL ED, GATE, ETC. – HOBBIES, TRANSITIONS, CHANGES:

1^{st} – 5^{th} Grade:

_____

_____

_____

_____

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SCHOOL ATTENDED:

_____

6^{th} – 8^{th} Grade:

_____

_____

_____

_____

SCHOOL ATTENDED:

_____

9^{th} AND UP:

_____

_____

_____

_____

SCHOOL ATTENDED:

_____

DESCRIBE YOUR CHILD/TEEN'S CHALLENGES:

_____

_____

_____

DESCRIBE YOUR CHILD/TEEN'S TEMPERAMENT:

_____

_____

_____

DESCRIBE YOUR CHILD/TEEN'S SUCCESSES AND QUALITIES:

_____

_____

_____

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PEOPLE YOUR CHILD/TEEN SEEMS TO TRUST AND RELATE WELL WITH:

_____

_____

_____

SYMPTOM CHECKLIST

Place a check mark next to the symptoms that you are experiencing. For EACH symptom checked, please note the severity (1-10 from least to most problematic) and how long you have been experiencing this.

1 □ Depressed mood

2 □ Feeling hopeless

3 □ Social withdrawal

4 □ Lack of interest in previously enjoyed activities

5 □ Changed sleep patterns (too much or too little)

6 □ Changed appetite (too much or too little)

7 □ Difficulty concentrating

8 □ Obsessive thoughts

9 □ Social anxiety

10 □ Panic attacks (check relevant symptoms):

- o palpitations, pounding heart, or accelerated heart rate
- o sweating
- o trembling or shaking

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- o sensations of shortness of breath or smothering
- o feeling of choking
- o fear of losing control or going crazy

- o fear of dying
- o numbness or tingling sensations
- o chills or hot flashes

- o chest pain or discomfort
- o nausea or abdominal distress
- o feeling dizzy, unsteady, lightheaded, or faint
- o feelings of unreality or being detached from oneself

1 □ Careless, poor attention to details

2 □ Difficulty sustaining attention

3 □ Unable to listen to others

4 □ Difficulty organizing

5 □ Tend to avoid effortful tasks

6 □ Often lose necessary things

7 □ Easily distracted

□ Irritability
□ Fatigue
□ Mood swings

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□ Recklessness
□ Thoughts of suicide
□ Suicide attempts
□ Self-harm (cutting, self-mutilating)

□ Forgetful in daily activities

□ Fidgety, unable to sit still

□ Always on the go
□ Acts as if driven by motor

□ Talking excessively

□ Difficulty waiting turn
□ Impulsive/ acts without thinking first

Other symptoms not noted above:_____
_____
_____
_____
_____
_____

Anything else that would be helpful to know:_____
_____
_____
_____
_____

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Confidentiality

Therapy is best experienced in an atmosphere of trust. All therapy services are confidential and information regarding our sessions cannot be revealed without your written permission. **There are exceptions to confidentiality where disclosure is required by law (see below).** There may be occasions where I consult with adjunct therapists in order to discuss aspects of our sessions in order to best support your process. Understand that I will not use your name and will change identifying details in order to protect your confidentiality. If you should request that I speak with another professional or person (i.e., doctors, former therapists, teachers, family or anyone else outside the therapy room), I will need your written consent, and will only do so after determining this is in the best interest of your therapeutic progress.

Conjoint Sessions

On occasion, and only if it benefits the client's therapy goals, I may ask that a family member or significant other join us for a therapy session. It is important to note that this is done only on occasion and at the therapist's discretion when it best serves the client. If a family member or significant other agrees to meet for a session, it will be for the client's benefit. Additionally, the third party [friend or significant other] is not joining the session for his or her own therapy, nor will I work with them as a therapist as my therapeutic alliance is with the client, not the family member or significant other. If we decide that this would be beneficial, you will need to sign a written release of information for this type of conjoint session.

Sobriety Policy

I ask that all clients, couples, families, group members arrive to therapy sober and not under the influence of illegal drugs and alcohol. If I notice that you are intoxicated (such as slurred speech, rapid speech, smelling of alcohol, behavior that indicates intoxication with cocaine, prescription drug abuse, or other substances) I will immediately end the therapy session, and assist you in finding a safe ride home (via friend, family member or taxi) as driving while under the influence constitutes a risk to others and is a reportable offense. Once you are safely home, I will reschedule the therapy session where we will process this occurrence. You will be charged your full fee for the session if you arrive intoxicated.

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Therapy Sessions

Therapy sessions are weekly, and are scheduled in advance. Standard sessions are 50-minutes in length and begin and end on time. Therapy can be conducted in office or via teletherapy [phone] if you are away on business or ill. The fee is the same for in-office or teletherapy, as I must block out the same amount of time. It is understandable that occasionally you may be late. If you are late to your session, please understand that the session will not extend past your 50-minutes, nor will the time be made up at future sessions, as this will impact other clients I see. Longer sessions are available by request and upon availability of my schedule at a prorated fee. If I find that your session tends to run longer we will discuss this in session in order to maintain healthy boundaries around starting and ending on time.

Non-Discrimination Policy

I respect each person's right to choose his or her own belief system. I work well with both the Christian client and the atheist client, as well as client's from many religions and beliefs. If a client would like to work from a faith-based approach, I am happy to discuss this with you and support your process. Additionally, I respect each person's right to their choices in terms of sexual orientation, and provide a safe place for both straight and gay clients.

I believe in supporting people of all ethnicities, cultures and physical challenges. While our gender, ethnicity, orientation or spirituality may be different, I am open to discussing any concerns or questions you may have in working with a therapist who is either a different race, religion, orientation or gender than you. Having an open discussion on any of these topics can lead to a greater level of trust and rapport. If you have any questions regarding my therapeutic approach and style, or my non-discrimination policies, please feel free to discuss this with me.

Court Reports or Letters

I do not write legal letters or court reports on behalf of clients involved involving divorce, custody or other legal matters or lawsuits. I do not write letters pertaining to legal matters to any outside person (i.e. doctor, school, attorney, etc) or agency regarding your treatment. If a special circumstance arrives where a letter is required by court order, it will require your written consent and will be billed to you at $25.00 per page and in

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addition to my hourly fee. I reserve the right to refuse to write letters on your behalf (unless court mandated) if I do not feel this would be in your best interest, if it places me in a dual relationship, or will compromise our therapeutic relationship. I will not write letters on your behalf if you are involved in a lawsuit for any aspect of your personal or professional life, as this places me in a dual relationship as both your therapist and court advocate, thus crossing therapeutic boundaries. If you are involved in a lawsuit, please understand that entering your mental health into a court hearing may not always be in your best interest as it may compromise your confidentiality and your clinical files may be requested. I will not be your advocate in a court hearing or speak on your behalf as that is not the nature of the therapist/client relationship. Please sign below that you (the parent) agree to these terms.

Signature:_____ Date:_____

Court Fees

If you become involved in legal proceedings that require my mandated participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the time involved and the interruption to my clinical work, I charge $250 per hour for preparation and attendance at any legal proceeding on your behalf.

Health Care/Managed Care Insurance Policy

In order for the therapist to be reimbursed by an insurance company, a diagnosis of the client must be made and submitted to the insurance carrier before the therapist is paid. Sometimes information on the presenting problem and symptoms the client is experiencing from the client's private therapy records are also required by the insurance company. This information once released becomes part of the client's medical records and may impact confidentiality. Because of this factor in confidentiality, I do not work with Managed Care Health Insurance programs. I will be glad to provide a 'superbill' receipt that you may submit to your insurance company if you wish for a **possible** out of network reimbursement, however, I will not fill out forms or work directly with or on your behalf with your health care insurance company.

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Additionally, is important that you also understand that there is no guarantee that your insurance carrier will cover your therapy sessions. I ask that clients carefully consider this before we begin our work together. If you choose to work with me, my policy is fee for service as described in the following section. Your signature indicates that you understand and agree to respect my policy around managed care health insurance, and will honor this agreement now and in the future.

Signature:_____Date:_____

Fees

My fee is $125 per 50-minute session. This fee is the same for in office, teletherapy [phone sessions], or couples therapy. For extended sessions the fee is increased. Therapy is an investment in self-care, and is a process that takes time. I ask that you meet my full fee unless you are facing serious financial hardship in which case we can discuss a sliding scale fee before the start of your first session that is mutually acceptable to us both. I have 4 sliding scale fee session spots which may be filled at any point in time. If you are not able to afford my fee even if the sliding scale is available, we will not be able to work together, but I will be happy to provide you with three (3) therapy referrals for low cost clinics that offer lower fees. If you utilize my sliding scale, from time to time we will revisit your fee and discuss a possible increase. Should your financial situation improve, I will then discuss an increase in your fee that either meets or is closer to my full fee.

Session Payments

Therapy sessions are to be paid in full at the start of each session at the time service is rendered. Payments may be via check written to Cathryn Leff, by cash, or by Visa, Master or credit/debit card. If you choose to pay (or feel that you may occasionally pay) with a credit or debit card, I ask that you please fill out the attached authorization form. I charge clients at the start of the day on the day of their session. Please note: If you choose to pay in cash, I do not carry change. It is your responsibility to bring the exact cash amount for your session fee. If a check is returned for insufficient funds, you will be responsible for reimbursing any bank fees incurred. Please note: Charges for unpaid

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services may be turned over to a collection agency which compromises confidentiality. I do not "carry over" session payments from week to week, or extend credit as this could constitute as an unethical "debtor/creditor" dual relationship and ultimately impact the therapeutic relationship.

Reduced Session Payments

As we move toward the final stage of therapy, we may discuss moving your sessions to every other week, vs. once a week in order to taper off for termination. Once sessions are reduced to two times a month, and/or check in sessions every few weeks, I ask that clients who have been using the sliding scale meet my full fee. If you are a client that will be starting with sessions twice a month, I ask that you meet my full fee. My fees are the same for in office or teletherapy [phone], or couples. Extended sessions are a billed at a higher fee [for example: 90 minutes is considered a double session and is billed as such].

Fee Increases

Fees are reviewed each year, and may increase periodically. Every consideration to client's current finances will be made, the increase will be discussed with the client, and a 30-day notice will be given prior to the increase. I will be happy to answer any questions you may have about this fee agreement. Please understand that you have the right to terminate therapy at any point. If you have any questions regarding my fee policy, please do not sign until discussing with me. Your signature indicates that you understand and agree to these conditions:

Signature_____Date_____

Appointments/Cancellations

My contact number is through my business phone at (951) 296-9460. If you are trying to reach me on the same day of your session, I ask that you contact me via phone, and not by email. I make every effort to return calls and emails within 24 hours. I understand that occasionally circumstances beyond your control may arise which would prevent you from keeping your appointment. The message number for cancellations is the same as above; this number is located on the business card that you will take with you today. If I

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am unable to attend our therapy session (outside of scheduled vacations) due to an unexpected emergency or illness, every attempt will be made to contact you 24 hours in advance on the phone numbers and/or email you have provided. If you are sick or experiencing any symptoms of illness, I ask that we conduct your session via the phone. I will extend the same consideration if I am ill.

Client Cancellation Procedures and Fees

Short-Notice Cancellation: Appointment cancellations made less than 24 hours of the scheduled appointment will be charged the agreed upon full fee for the session.

No-Show: If you do not show up for a scheduled appointment (that you have not called to cancel) you will be charged the full fee for the session. If you tend to forget appointments please let me know – I will be happy to email you in advance to confirm our sessions. However, you are responsible for keeping track and attending your sessions.

On-going Cancellations or Multiple No-Shows: It is understandable that occasionally an appointment will be cancelled or missed due to illness or emergency. However, your regular session day/time has been reserved for you. My current client schedule does not allow for a great deal of flexibility with respect to continual cancellations, rescheduled appointments, or no shows. If you find that your schedule is no longer able to accommodate the session time reserved for you, please discuss this with me and I will do my very best to find an alternative solution, such as phone sessions, so that we can continue our work together. However, please note that should on-going cancellations, frequent reschedules even within the same week, missed appointments, late payments/ non payment become an issue, and if after discussing other options with you your attendance has not changed, I will need to open up your reserved time to my wait list and add you to the wait list. If you prefer not to be placed on the wait list, then I will provide you with three therapy referrals and/or terminate with you until you are able to attend.

Signature_____Date_____

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Therapist Availability Between Sessions

I am available to take a brief 5-minute phone call or answer a short 1 paragraph email regarding your therapy appointment times or therapy homework one time between sessions and no more than 1 time per month without the client incurring a fee. We will part of your treatment. If you feel that more contact is needed between sessions due to crisis, I am willing to discuss the possibility of increasing the weekly sessions or scheduling a phone appointment temporarily if I feel that it supports your therapy. If frequent non-crisis contact continues between sessions, it will be important to talk about charging for that support time, and/or referring out for a higher level of care than a once a week therapy session can offer.

Therapist Time Off Policy

During my out of office time, I will not be available for individual session, group, family or couples therapy both in person, via email, text or phone unless it is a serious crisis, or life threatening emergency where there is imminent danger to self or others. If you are a threat to yourself or another when I am away, please call 911 immediately. On occasion I may provide the phone number and contact information of a therapist colleague who may fill in during my time away for emergency situations. I ask that clients respect my time away and unless there is a critical emergency, they wait until the next session to discuss. For emergency situations, I will respond to the client within 24 hours of receipt of the email, call or text. For non-emergency clients, I will respond the first business day upon returning back to my office.

Your signature indicates your agreement to my boundaries around client contact during my vacations: _____

Explanation Of Dual Relationships

While a therapeutic relationship can feel psychologically close, it is one that is professional in nature with important boundaries. It is unethical for a therapist to invite you into a business venture, ask you for personal favors, start a social relationship with you, etc. These examples are called, “dual relationships” and can negatively impact

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clinical boundaries. Although our sessions may be intimate psychologically, it is important to acknowledge that we have a strictly professional relationship. On the rare occasion that I see a client outside of the office (when we may accidentally run into each other in public), I am highly discreet and will maintain your confidentiality. I will do my best to follow your lead, and thus it is your choice to acknowledge the encounter with me as your therapist or not. If you do not choose to acknowledge the encounter, I will respect this and will follow your lead.

Policy Regarding Internet Professional and/or Social Networking Sites

On occasion a client will send me an on-line invitation or "friend" request through a social networking site. Unfortunately, this could potentially risk the client's confidentiality. As such I choose not to accept these requests from clients.

Physical Contact

Sexual contact is never acceptable in the therapeutic relationship. Romantic or sexual talk, or sexual innuendos and sexual jokes are also unacceptable in the therapeutic relationship. If you should express a sexual comment or joke while in session directed to me, we will explore this comment professionally and in a non-shaming way within a therapeutic non-sexual relationship. Hugging is an expression of affection, a greeting or a good bye within many cultures. However, in some cases hugging can be misconstrued as sexual, and can be triggering for some clients, or may interfere with the therapy relationship. Occasionally a client may spontaneously hug me while they exit my office, or may ask for a hug after a particularly difficult or emotional session, or may feel quite comfortable with a hug at the end of sessions or when ending therapy. Some clients are huggers, some are not, and so it is important for me to understand your stance and to maintain appropriate professional boundaries. If I believe after we discuss the request that a non-sexual brief hug is appropriate and supports your therapy, I will allow for this on occasion. Please understand, if I choose not to hug you, it is not an expression of judgment, dislike or dismissal, rather it would be denied in the best interest of your clinical care based on a therapeutic decision.

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FORM COMPLETED BY:

_____

Patient Signature:_____

Date:_____ (if applicable)

Printed Name:_____

TEACHER: _____

Printed Name:_____

Parent 1 Signature:_____

Date:_____

Parent 2 Signature:_____

Date:_____

Printed Name:_____

Parent 3 Signature:_____

Date:_____

Printed Name:_____

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AUTHORIZATION TO TREAT MINORS

I/we, _____(name of parents/ guardians), give my/our permission to Charlottesville Counseling Services to see my/our child/custodian, _____ (name of minor child), for counseling with or without me being present in the same session. I/we understand that we are the holder of confidential privilege. However, in the interest of developing a trusting relationship between the counselor and my/our child, I/we give the counselor permission to reveal or withhold information that in his/her clinical judgment is necessary to best help and treat my/our child.

The only exception to this agreement would be in the case of

_____

_____

_____

(Signature parent/guardian) (date)

Print name of parent/
guardian:_____

_____

(youth signature) (date)

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