Sound Living Counseling Center
6727 Heritage Business Court, Suite 720, Chattanooga, TN 37421|Office Phone: 423-682-7203|office@soundlc.com

Child Intake Form

Date of Intake: ____/__/_____

A. Child Information

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

Gender: ☐ Male ☐ Female ☐ Not Listed: _____ Social Security #: _____

Race/Ethnicity: ☐ African American/Black ☐ American Indian or Alaskan Native ☐ Asian

☐ Hispanic ☐ Native Hawaiian ☐ White ☐ Multi-Racial ☐ Not Listed: _____

School require notice of attendance? ☐ Yes ☐ No

B. Parent / Guardian Information

Parent / Guardian Name:_____ Relationship:_____

Date of Birth:_____ Address:_____

City:_____ State:_____ Zip:_____

Best Contact #:_____ ☐ Home/Cell or ☐ Work Email:_____

Preferred method of contact: ☐ Home/Cell|☐ Work|☐ Email |Ok to leave message/text? ☐ Yes ☐ No
(Please be advised that call/emails will be discreet)
Parents are currently: ☐ Married ☐Divorced ☐Remarried ☐ Never married ☐ Not Listed: _____

Emergency Contact: By listing the contact information below and **initialing here_____**, you are giving Sound Living Counseling Center (SLCC) permission to contact this person in the event of a physical or mental health emergency including but not limited to a life-threatening situation, a client's death/incapacitation, or imminent risk of harm to self/others should such contact be deemed beneficial by the SLCC staff member(s):

Contact Name: _____ Phone #: _____

Relationship: _____ Address: _____

City:_____ State:_____ Zip:_____

C. Community

Residences

Dates		Location	With whom?	Reason for Moving	Any Problems?
From	To				

Schools

School (Name, District, Address, Phone)	Grade	Age	Teacher

D. Early Development

Pregnancy and Delivery

Prenatal Medical Illnesses and Health Care:

Was child premature? ☐ Yes ☐ No Weight and height at birth?

Was child breast fed? ☐ Yes ☐ No For how long?

Birth Complications or Problems:

Allergies:

Milestones – At what age did this child do each of these?

Sat without support: _____ Crawled:_____

Walked without holding on:_____ Helped when being dressed: _____
Ate with a fork:_____ Stayed dry all day:_____
Didn't soil their pants: _____ Stayed dry all night:_____
Tied shoelaces: _____ Buttoned buttons: _____

Speech / Language

Age when child said first word understandable to a stranger: _____
Age when child said first sentence understandable to a stranger: _____
Any speech, hearing, or language difficulties? _____
_____

Siblings

Name	Age	Gender	Grade	Is this a step-sibling?	From previous relationship?	Live with you?	Mental Health diagnosis?

Family and Extended Family History

	Current Age (or age at death)	Medical Illness Diagnosis (or cause of death)	Mental Health Diagnosis
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Step-parent			
Step-parent			

E. Referral Source – How did you find Sound Living Counseling?

☐ Employer ☐ Friend ☐ Hospital ☐ Physician/Psychiatrist ☐ Counselor ☐ Other _____

Name/Business/Organization:_____ Phone #: _____

Address if known:_____

Permission to send "thank you" to referral? ☐ Yes ☐ No
(SLCC would love to thank each of our referral sources if the client is comfortable with us reaching out)

F. Reason for seeking assistance:

Chief Complaint:_____

History of Present Illness: -Diagnoses, by whom and when?

_____

_____

_____

Have you seen another Behavioral health clinician in the past 6 months? ☐ Yes ☐ No

Past or current Psychiatric/ Psychological Treatment, by whom and when?

_____

_____

_____

Past Major Medical/ Surgical History, by whom and when?

_____

_____

_____

A. Medical

PCP Name: _____ Phone#: _____

Current Medication List

Medication:	Dose:	How Long on This Med?	Frequency:	Prescriber:	Reason:

Describe any medication changes within the last 6 months:

Please describe your physical health over the past 6 months:

Do you exercise? ☐ Yes ☐ No If so, how and how often?

Suspicious Drugs (Allergies):

Drugs generic name ± additives indications:	Daily dose / Route of application / duration of therapy:	Interval between dose and interaction	Previous therapy with this drug:
1.	……..mg/d……..;……d		☐ no ☐unknown ☐ yes, Symptoms _____
2.	……..mg/d……..;……d		☐ no ☐unknown ☐ yes, Symptoms _____
3.	……..mg/d……..;……d		☐ no ☐unknown ☐ yes, Symptoms _____
4.	……..mg/d……..;……d		☐ no ☐unknown ☐ yes, Symptoms _____
5.	……..mg/d……..;……d		☐ no ☐unknown ☐ yes, Symptoms _____
6.	……..mg/d……..;……d		☐ no ☐unknown ☐ yes, Symptoms _____

Drug / Alcohol Assessment

Which substances are currently used:	**Method of use: Oral, Inhalation, Intranasal, Injection.**	**Amount of Use**	**Frequency of Use: (Times/Month)**	**Time Period of Use**	**If not currently using, have you used it in the past?**
Alcohol					
Caffeine					
Nicotine					
Opiates					
Marijuana					
Meth					
Stimulants					
Hallucinogens					
Other					

Harm Risk Assessment:

Have you had thoughts about death or dying: ☐ Yes ☐ No

Have you had thoughts about hurting someone else: ☐ Yes ☐ No

Previous Attempt(s) When: _____

1.) In the past month, have you wished you weren't alive or wished you could go to sleep and not wake up?
☐ Yes ☐ No
2.) Have you had thoughts of actually hurting yourself or hurting other people?
☐ Yes ☐ No
3.) If yes, do you feel that you can handle the thoughts without acting on them?
☐ Yes ☐ No
4.) Do you need a safety plan or a number to call when having these thoughts?
☐ Yes ☐ No
5.) High Risk Behaviors?

☐ None ☐ Cutting ☐ Anorexia/Bulimia ☐ Head Banging ☐ Self-Injurious Behaviors

Describe any traumatic experiences:

_____

_____

_____

Coping Skills

Describe how you handle stressful situations:

_____

_____

What hobbies or fun activities do you enjoy?

_____

_____

What are you good at? What talents or gifts do you have?

_____

_____

_____

What are your needs?

What are your strengths?

What are your challenges?

What are your personal goals?

Abuse Assessment

In the past year, have you been hit, kicked, or physically hurt by anyone: ☐ Yes ☐ No

Have you ever been forced to have sexual contact: ☐ Yes ☐ No

Have you ever been in a relationship with someone who hurt you: ☐ Yes ☐ No

If yes, are you currently in this relationship: ☐ Yes ☐ No

If yes, do you need help creating a safety plan: ☐ Yes ☐ No

B. Medical

Clinic/Physician Name: _____ Phone#: _____

Current Medication List

Medication:	Dose:	How Long on This Med?	Frequency:	Prescriber:	Reason:

Describe any medication changes within the last 6 months:

_____

_____

_____

Drug / Alcohol Assessment

Which substances are currently used:	Method of use: (eaten, drank, smoked, etc.)	How much do you use?	How often do you use? (Times/Month)	Time Period of Use	If not currently using, have you used it in the past?
Alcohol					
Caffeine					
Tobacco / Vape					
Marijuana					
Other: _____					

Informed Consent

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and your counselor to work effectively together, we ask that you carefully read the information below. If you have any questions, your counselor will be happy to discuss them with you.

Introduction:

Sound Living Counseling Center is in place to serve the needs of people in the community and the church. The mission is to make a difference in families and individuals utilizing family systems theory, solution focused therapies and faith-based practices that encourage hope and motivate success. This office provided hope, help and healing to men, women, adolescents, couples, and families.

If a client appears to need additional services such as medication management, evaluation of child for custody issues or the possible occurrence or extent of abuse, we will provide referrals to appropriate professionals within the patient's community. It is important to note that we cannot provide forensic evaluations as part of this facility.

Counseling Fees:

Price	Description	Duration
$110	Intake – Psychiatric diagnostic interview examination	1 – 2 unit/hours
$90	Individual Psychotherapy	1 to 2 unit/hours
$100	Individual Psychotherapy	60 minutes (1unit/hour)
$100	Family Psychotherapy, without the patient present	1 to 2 unit/hours
$100	Family Psychotherapy, with the patient present	1 to 2 unit/hours
$50	Group psychotherapy	1 hour
$0 - $45	Sliding Fee scale available for those without insurance	1 to 2 unit/hour

We ask that your account be kept current and that your payment be made by check or cash prior to each session. Should the agreed upon fee not be paid for three sessions no further sessions will be scheduled until the balance is paid, unless you have discussed this issue and worked out an agreement with your counselor.

Please make checks payable to: **Sound Living Counseling Center**
Sound Living Counseling Center can also apply donations to the fee or fees for services. This may include, but not be limited to, donations to finance all or part of the client's cost for services; or payments made to the agency for a client's participation in an employment or rehabilitation program to finance the cost of services provided.

Hours of Operation

Sound Living Counseling Center is operated 9am-5pm Monday through Thursday, other hours may be available by appointment. Please call 423-682-7203 for scheduling.

Insurance:

We accept the following insurance cards: Access one EAP, Aetna, Alliant, Amerigroup, Blue Cross Blue Shield, Blue Care, Cigna, ComPsych, Cover Tennessee, Humana, Life Synch, Magellan, Magellan EAP, Optimum, Tricare, United Healthcare and Value Options. If you need

assistance and your insurance company is not listed please let us know as we are willing to contract with other insurance companies as needed.

Confidentiality Policy

Your privacy is important to us, and we believe that counseling is most effective when clients feel comfortable speaking openly with their counselor. We hope this information will clarify our privacy policies.

In the usual course of events, you have the right to keep your counseling here completely private. This means that, without your written permission, no information about your contact with Sound Living Counseling Center is available to anyone outside of this facility, including parents, family members, friends, or outside agencies. Please ask us if you have any questions about this, as we want to be sure you are comfortable with our practices.

There are certain exceptions to confidentiality, noted below, with which you should be aware before you enter into any counseling relationship. Please read carefully through these exceptions, and be sure to ask your counselor if you have any questions.

Exceptions to Confidentiality:

- If appropriate, your counselor may consult with your treating physician or other healthcare providers to coordinate your care or use your case for training purposes. If we consult a provider you will be asked to sign a release of information (ROI). If used for training purposes, no identifying information will be disclosed.
- If you pose a threat of harm to yourself, or to another person, we will take whatever steps are required by law, or permitted by law, to help prevent the potential harm from happening. This may include contacting your family.
- In the event of a psychiatric hospitalization we will consult a facility and you will be asked to sign a release of information (ROI).
- If you report information indicating that a child, disabled, or elderly person is suffering from abuse or neglect we are mandated state reporters.
- A court order, issued by a judge, could require us to release information contained in your records. For your protection, we prefer not to attend court and if required fees may apply.
- In the event you approve, an intern may be able to shadow for educational purposes. This student will also be held accountable for the confidentiality of the client, and will only consult with the therapist at hand.

Cancelation of appointments:

If you must cancel your appointment, please call 423-682-7203 and leave a message on your counselor's voicemail or text counselor directly at least 24 hours in advance of your scheduled appointment. Your cooperation in this regard will be greatly appreciated.

Telephone calls:

Should you need to contact your counselor, you may leave a message our voicemail or contact via your counselor's cell phone. Our voicemail system will receive your message 7 days a week, 24 hours a day. Your call will be returned as soon as possible during week days.

Emergency procedures:

Since the counseling office is not staffed 24 hours per day, the counselors are not available to handle after hours emergencies. If you have an emergency, you will need to contact either a hospital emergency room or call 911 depending on the situation. Hamilton county residents may also call the *Mobile Crisis* number *at 423-634-8995.*

Additional Important Phone Numbers

Chattanooga, TN Police	911 or (423) 698-2525
Sound Living Counseling Center	(423) 682-7203
After-Hours Suicide Prevention Hotline	1-800-273-8255
Sound Living Counseling Supervisor	(423) 505-5475
Sexual Assault Crisis Center	(423) 755-2700
Domestic Violence and Crisis	(423) 755-2700
Behavioral Health Crisis Hotline	1-800-704-2651

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" handouts and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. *I* understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that l may end my services with my therapist at any time, and the only thing I will be responsible for is paying for the services I have already received. I understand that by ending this service, if it was ordered by the court or my employer, my therapist will follow-up as appropriate to update the referring party.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive has not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

Signature of Parent / Guardian	Date
Printed name	Relationship to client (if necessary)