

Date of birth:		
Marital status:		
Date of marriage:		
Date of separation (if applicable):		
Date of divorce (if applicable):		
Date widowed (if applicable):		

Does your family have a religious affiliation? If so please describe: _____

Who has legal custody of child? _____

With whom is child currently living?

_____ **Biological parents**

_____ **Adoptive parents**

_____ **Foster parents**

_____ **Biological mother only**

_____ **Biological father only**

_____ **Biological mother and stepfather**

_____ **Biological father and stepmother**

_____ **Relatives (names: _____)**

_____ **Institution (name: _____)**

_____ **Other: _____**

If child is adopted, what factors led to parent(s) decision to adopt? _____

Sibling information:

NAME	DATE OF BIRTH	RELATIONSHIP (full/half sib., foster, biological, adopted?)	CURRENTLY LIVING (in home, away at school, with another family, etc.)

Information about others living in the home:

NAME	AGE	GENDER	RELATIONSHIP TO CHILD

How would you describe your child's physical appearance? (e.g. height, weight, eye and hair color, distinguishing characteristics, manner of dress):

With whom has child lived in the past?

(Please record as much information as you can. Placements should include any hospitalizations and interim moves, no matter how brief. Use additional pages if needed).

DATES	TYPE OF PLACEMENT*	NAMES OF CAREGIVERS	REASON FOR MOVE

***TYPE OF PLACEMENT: Birthparent(s), birth relative(s), foster parent(s), adoptive parent(s), step parent(s), group home, institution, residential treatment center, other.**

PLEASE DESCRIBE CHILD'S BIRTH AND DEVELOPMENTAL HISTORY, IF KNOWN:

Age of birthmother at time of child's birth: _____
Birthmother's total number of pregnancies: _____
(this child was pregnancy # _____)
miscarriages: _____
abortions: _____

Problems during pregnancy with this child:

_____ None
_____ Unusual swelling
_____ Unusual weight gain (if yes, how much? _____)
_____ Unusual weight loss (if yes, how much? _____)
_____ High blood pressure
_____ Infection
_____ Bleeding
_____ Unusual vomiting
_____ Medicines taken during pregnancy (please list names and reasons for taking): _____
_____ Disease or exposure to contagious disease (please explain): _____
_____ Persistent emotional stress, depression, or anxiety (please explain): _____
_____ Smoking during pregnancy
_____ Alcohol use
_____ Use of street drugs (please list) _____
_____ Other: _____

Did birthmother have prenatal care? _____ When? _____

Was pregnancy full-term? _____ Premature? _____

Was mother depressed during the pregnancy? _____

Was mother ambivalent about the pregnancy? _____ Why? _____

Was father supportive during the pregnancy? _____ If not, why? _____

Was mother on any type of medication during pregnancy? (If so, please list medication and reason for use): _____

Delivery occurred during the _____th month of pregnancy

How long was labor? _____ Natural? _____ Induced? _____

Were there any complications during labor? _____ If yes, please explain:

Was delivery at home? _____ In a hospital? _____ Other? _____

Was delivery attended by a physician? _____ Midwife? _____

Other? _____

Was delivery normal? _____ If not, were forceps used? _____

Was birth breech? _____ Was cord wrapped around infant's neck? _____

Was a Caesarean section performed? _____

Was this a multiple birth? _____ If so, how many? _____

Did all survive? _____

What was child's birth weight? _____ Length? _____

At birth, was the infant jaundiced? _____ Did s/he experience anoxia (oxygen deficiency)? _____ Was an incubator necessary for an extended

period of time? _____ If so, how long? _____ Were caregivers allowed to take infant out of incubator and hold him/her? _____

Was the infant diagnosed with in-utero alcohol exposure? _____

Was the infant diagnosed with in-utero drug exposure? _____ If yes, to which drugs? _____

Did examination at birth reveal any physical disorders? If so, please explain:

Mother's health after childbirth was good _____ poor _____. If poor, please explain: _____

On what day in the hospital did mother first see the baby? _____

Did mother hold the baby? _____. If so, on what day? _____

How long were mother and baby in the hospital before coming home? _____

Were there problems with child in the hospital before coming home?

_____ **No problems**

_____ **Infection (what type?)_____**

_____ **Convulsion**

_____ **Pain (please describe) _____**

_____ **Other (please explain) _____**

How did mother respond to the child's fussiness? _____

During infancy, were any of the following problems present?

_____ **Weak crying response**

_____ **Constant whining**

_____ **Rageful crying**

_____ **Extremely sensitive to touch**

_____ **Extremely resistant to cuddling**

_____ **Limp when held**

_____ **Stiff when held**

_____ **Child arched back and resisted being held**

_____ **Poor sucking response**

_____ **Poor eye contact, lack of tracking with eyes**

_____ **No reciprocal smile response**

_____ **Indifference to others**

_____ **Choked easily**

_____ **Vomited or spit up frequently**

_____ **Child was unusually nervous or jittery**

_____ **Child had colic (until age: _____)**

_____ **Difficulty swallowing**

_____ **Difficulty chewing**

_____ **Held breath for long periods of time**

_____ **Had allergic reactions to: _____**

_____ **Other: _____**

Please describe child's small muscle development (e.g. using a pencil, doing puzzles):

Which hand does child prefer to use? _____ Is preference consistent? _____

Is child's speech normal? _____ If not, please describe: _____

Has child ever had speech therapy? _____

Is child's hearing normal? _____ If not, please describe: _____

Has child received vision therapy? _____ If so, please describe: _____

MEDICAL INFORMATION (must be completed):

Name of child's physician: _____

Physician address: _____

Physician phone: _____

Date of most recent physical examination: _____

What is child's present health condition? _____

Does child have any health problems? If so, please describe: _____

Please list child's medications below, beginning with current medication, and working backward:

Dates	Name of Medication	Amount (ex -10 mg.)	Taken when:	Prescribed by:	Child's reaction:

EDUCATION: Please list all schools attended, beginning with the current school:

DATES AND GRADES ATTENDED	NAME OF SCHOOL	ADDRESS AND TELEPHONE NO.	BEHAVIOR PROBLEMS, IF ANY

Does your child enjoy being in school? Specific likes and dislikes: _____

Has your child been diagnosed with learning disabilities? If so, please indicate: _____

Please list your child's positive qualities:

What questions would you like to have answered about your child? _____

Professional Counseling or Therapy	Dates	Therapist's name, address, phone	Results
This child:			
Mother:			
Father:			

Brother(s):			
Sister(s):			
Family:			

Information in this intake form provided by: _____

Relationship to child: _____

Date provided: _____

FAMILY HISTORY (to be filled out by each parent):

Parent #1 _____

Family of Origin

Describe your mother and father (positive and negative qualities):

How did your parents show affection to each other and their children?

How did your parents handle disagreements and conflicts; what were their main methods of discipline?

How many siblings do you have? _____

What role did each sibling play in the family?

Does your family have a history of alcohol or drug abuse? If so, please describe, including how the issue was dealt with: _____

Was there physical, emotional or sexual abuse in your family? If so, please describe, including how the issue was dealt with: _____

Was there mental or emotional illness in your family? If so, please describe, including how the issue was dealt with: _____

On a scale of one to ten, with ten being the most stressful, how stressful was the home in which you grew up? Why do you think this was so? _____

Medical History

List any current/past illnesses/injuries that have impacted you or your family:

Marital History

Describe your current marriage, including both positive and negative qualities (e.g., intimacy, communication, problem-solving, togetherness).

Briefly list and describe any previous marriages.

Current Family

List your other children and give a brief description of each child.

What are your main methods of discipline and how effective have they been?

What concerns do you have with any other member of the family?

How large of a role, if any, does religion play in your family?

Describe your family's positive attributes, strengths and support systems: _____

How many siblings do you have? _____

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Describe your family's positive attributes, strengths and support systems: _____

Place a check next to each behavior your child currently exhibits or has exhibited.

1. Is excessively distressed when separated from family
2. Exhibits excessive anxiety or worry
3. Has difficulty arising in the AM
4. Is hyperactive and excitable in the PM
5. Sleeps fitfully or has difficulty getting to sleep
6. Has night terror or frequently wakes in the middle of the night
7. Is unable to concentrate at school
8. Has poor handwriting
9. Has difficulty organizing tasks
10. Has difficulty making transitions
11. Complains of being bored
12. Has many ideas at once
13. Is very intuitive or very creative
14. Is easily distracted by extraneous stimuli
15. Has periods of excessive, rapid speech
16. Is willful and refuses to be subordinated
17. Displays periods of extreme hyperactivity
18. Displays abrupt, rapid mood swings
19. Has irritable mood states

- 20. Has elated or silly, giddy mood states
- 21. Has exaggerated ideas about self or abilities
- 22. Exhibits inappropriate sexual behavior
- 23. Feels easily criticized or rejected
- 24. Has decreased initiative
- 25. Has periods of low energy or withdraws or isolates self
- 26. Has periods of self-doubt and poor self-esteem
- 27. Is intolerant of delays
- 28. Relentlessly pursues own needs
- 29. Argues with adults or bosses others
- 30. Defies or refuses to comply with rules
- 31. Blames others for his or her mistakes
- 32. Is easily angered when people set limits
- 33. Lies to avoid consequences of actions
- 34. Has protracted, explosive temper tantrums or rages
- 35. Has destroyed property intentionally
- 36. Curses viciously in anger
- 37. Makes moderate threats against others or self
- 38. Has made clear threats of suicide
- 39. Is fascinated with blood and gore
- 40. Has seen or heard hallucinations

TREATMENT CONTRACT

I(we) _____ voluntarily enter into this Agreement with the staff of The Institute for Child and Family Development to provide treatment services for _____, age _____, date of birth: _____ (hereinafter referred to as "Child"). I (we) agree to participate in the therapeutic process as well.

I am (we are): _____ Adoptive parent(s)
_____ Biological parent(s)
_____ Legal guardian(s)
_____ Placing Agency of _____

I am (we are) aware that there are certain risks inherent in treating children with severe emotional problems. Potential effects, though rare, could include: a worsening of symptoms, increasing difficulty in relationships between parents or between parents and child, surfacing of repressed memories in both children and parents, presentation of false memories, false allegations of abuse, suicidal ideation or psychotic episodes. These risks are greater if child and family do not complete the program, or if they do not follow the treatment plan developed by the staff of The Institute for Child and Family Development.

I (we) agree that the proper jurisdiction and venue for any action shall be in Orange County, California, and shall be construed in accordance with California Law.

Our codes of ethics and various laws of the state of California insure that the conversations you will be having with your therapist will be held in the strictest confidence. Matters you share in your counseling session will not be disclosed without your permission in writing. There are, however, certain exceptions to this rule that you need to know, in case any of them concern you in the future. Legal and ethical requirements specify certain conditions in which it may be necessary for your therapist to discuss information about your treatment with other professionals, significant others in your life, authorities or institutions. If you have any questions about these limitations, please ask about them before we begin treatment or at any time during our treatment. Such situations include but are not confined exclusively to the following:

1. If your therapist believes there is a danger that you may harm yourself or others or that you are incapable of caring for yourself.
2. If your therapist becomes aware of your involvement in the abuse of children, elderly or disabled persons.
3. If your therapist is ordered by a Court to release records. This sometimes happens when clients are plaintiffs or defendants in lawsuits and psychological records are

subpoenaed as part of that process. Typically, this is because you disclose having been in therapy.

4. If your insurance company requests records in order to verify the services received and determine compensation.

Occasionally, in order to provide you with the best possible services, your therapist may consult with a senior advanced therapist if it is believed that additional expertise would be helpful. This is always done in a way so that certain details are camouflaged, and your full identity is never revealed. We also make it a habit to consult with clinicians outside of Orange County.

This Treatment Contract is effective beginning _____ and will remain in effect until either party wishes to terminate by giving notice in writing. Parent(s) guardian(s) or placing agency do not need to give a reason for termination, but agree to bring the child in for a termination session with the child's therapist. This ensures closure in the treatment relationship between the child and his/her therapist.

This Treatment Contract is intended as the complete integration of all understandings between the parties, and shall be binding upon the parties hereto and their respective heirs, personal representatives and assigns.

We have carefully read and fully understand this Treatment Contract and will abide by its terms.

EXECUTED this _____ day of _____, 20____.

PARENT(S), GUARDIAN(S), OR PLACEMENT AGENCY

By _____

Street Address

City, State, and Zip

Phone(s)

Connie Hornyak, LCSW, Clinical Director, LCS 7096
1538 E. Warner Ave., Ste E
Santa Ana, CA 92705
(714) 751-7790

FEE AGREEMENT

I(We), _____ agree to pay for the treatment of _____ by The Institute for Child and Family Development.

I(We) agree to be responsible for payment to The Institute for Child and Family Development for all services rendered. I(We) understand that the staff of The Institute for Child and Family Development will assist us in collecting insurance reimbursement, but that I am (we are) ultimately responsible for obtaining this reimbursement. Costs of sessions are as follows:

PSYCHOTHERAPY FEES

Individual or Family Psychotherapy, 100 minutes	\$300.00
Individual or Family Psychotherapy, 75 minutes	\$225.00
Individual or Family Psychotherapy, 50 minutes	\$150.00
Individual or Family Psychotherapy, 25 minutes	\$ 70.00
Individual or Family Psychotherapy, 15 minutes	\$ 35.00
Three-session assessment	\$675.00
Three-session assessment with report	\$975.00

INTENSIVE PSYCHOTHERAPY FEES

One-week intensive program (children)	\$4,950.00*
Additional sibling intensive done concurrently	\$2,475.00*
Two-week intensive program (children)	\$9,990.00*
Additional sibling intensive done concurrently	\$4,950.00*
One-week intensive program (adults)	\$3,000.00*
Two-week intensive program (adults)	\$6,000.00*

*If the level of complexity for any particular case requires the use of additional treatment professionals other than those included in the intensive program, this rate may increase. In this event, clients will be so advised and additional fees discussed in advance.

Additional intensive program charges, if needed:

Follow-up treatment	150.00/hr. per therapist
Psychological testing	dependent upon tests needed
Follow-up consultation with hometown therapist	no charge

NOTE: There is a 50% non-refundable deposit required for intensive programs, due one month prior to the start of the intensive. The balance is due the first day of treatment. Payment is accepted by cashier's check only (no personal checks).

Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify your therapist if any problem arises during the course of your therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. You will be provided with a receipt that you can submit to your insurance company for reimbursement. If the insurance company has forms for the psychotherapist to complete, be certain to give them to the therapist at your earliest convenience. In instances where extraordinary professional time is required, you may incur additional fees.

The above costs include administrative fees. We do not charge for phone conversations unless they exceed ten minutes or they become excessive in frequency. If you become involved in any litigation and we have to appear in Court, write a report, or give testimony, we will charge \$260 per hour, payable in advance. The same charges apply to travel time.

Extra services such as contacts with others (e.g. psychiatrists, social workers, previous psychotherapists, school personnel), correspondence or report writing will be billed at \$150 per hour.

Travel time (such as travel to and from home visits, school conferences, meetings with others involved in client's treatment) will be at \$150 per hour or fraction thereof.

Report writing will be billed at \$150.00 per hour or fraction thereof.

We do understand that emergencies can arise which may prevent you from keeping your weekly appointment. We will therefore balance off your needs and ours in the following fashion: If you give us 24 hours notice of your intention not to use your appointment time, we will not charge you for the time. With such notice, we can make alternative plans. If you fail to provide us notice at least 24 hours in advance, or if you fail to show up as expected, we shall charge you for the time at the usual rate. Please note that insurance carriers do not reimburse for missed appointments and often require that such missed appointments be so noted on your statement of charges. Repeated failures to attend scheduled sessions or to provide adequate rescheduling notice may lead to termination of our work together.

I (We) understand that Intensive Programs require at least two weeks notice for cancellation.

I(We) have carefully read and fully understand this Fee Agreement and will abide by its terms.

_____ Date: _____
Client (if minor, parent or guardian)

_____ Date: _____
Parent or guardian

_____ Date: _____
Parent or guardian

OTHER DOCUMENTS TO RETURN WITH THIS INTAKE PACKET

Copies of official records describing child’s background and removal from birth parent(s):

- Court records
- social services records
- police reports

Do you need assistance with obtaining funding reimbursement? If so, please list the sources from which you intend to request funding:
