Child/Adolescent Intake Questionnaire

TriHealth EAP

(Please Print)

Child's/Adolescent's name _____

Date of birth_____

Parent (s') names _____ _____

What company is your EAP benefit through? _____

What brings your child/adolescent to counseling?

_____

_____

What are the goals for counseling?

_____

_____

FAMILY

People Living in Your Household:

Name	Age	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List sibling(s) not currently living in the household:

Name	Age	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Rev 01/2019

Who has custody of your child?

☐ Birth parents ☐ Father only ☐ Mother only ☐ Joint custody

☐ Other, please explain_____

Is your child experiencing any problems in relationships with: (check all that apply)

☐ Childcare providers/ teachers ☐ Father ☐ Mother ☐ Step-parent

☐ Siblings ☐ Step-siblings ☐ Friends ☐ None

☐ Other, please explain _____

EDUCATION

School your child/ adolescent attends_____

Grade_____

Please explain any school related issues, such as attendance, peer relationships, academic issues, or behavior.

_____

_____

HEALTH HISTORY

Primary Care Physician/ Pediatrician _____

Date of last visit to doctor_____

Height_____ Weight _____

Trouble sleeping	☐ Yes	☐ No
Change in appetite in the last month	☐ Yes	☐ No
Use of tobacco, e-cigarettes or vape	☐ Yes	☐ No

Please explain any issues with eating/ nutrition, sleeping or use of tobacco products.

_____

_____

Does your child have any significant medical conditions?

_____

_____

List the specialists' they see_____

Medications your child currently takes

_____

_____

Please describe any concerns with your adolescent's sexual activity or development.

_____

_____

BEHAVIORAL HEALTH

Has your child had previous counseling ☐ Yes ☐ No

Been in alcohol or drug treatment ☐ Yes ☐ No

If yes, please provide the name of the therapist and/ or treatment program. When?

Has your child: (check all that apply)

Talked about suicide	☐ Yes	☐ No	Threatened physical harm	☐ Yes	☐ No
Attempted suicide	☐ Yes	☐ No	Harmed a pet or small animal	☐ Yes	☐ No
Cut or mutilated their body	☐ Yes	☐ No	Run away from home	☐ Yes	☐ No

If yes, please describe.

Has your child witnessed or experienced: (check all that apply)

Emotional abuse	☐ Yes	☐ No	Domestic violence	☐ Yes	☐ No
Physical abuse	☐ Yes	☐ No	Other significant trauma	☐ Yes	☐ No
Sexual abuse	☐ Yes	☐ No			

If yes, please explain.

In daily activities, does your child find it difficult to: (check all that apply)

Adapt to change	☐ Yes	☐ No	Follow directions	☐ Yes	☐ No
Problem solve	☐ Yes	☐ No	Perform good hygiene	☐ Yes	☐ No
Make decisions	☐ Yes	☐ No	Focus on a task	☐ Yes	☐ No

If yes, please describe.

What has occurred recently in your child's life: (check all that apply)

Death in the family	☐ Yes	☐ No	Divorce or separation	☐ Yes	☐ No
Move to a new location	☐ Yes	☐ No	Frightening experience	☐ Yes	☐ No
Significant trauma	☐ Yes	☐ No			

Serious illness or injury to family member or friend ☐ Yes ☐ No

If yes, please describe.

ALCOHOL AND DRUG HISTORY

Describe what you know about your adolescent's alcohol and drug use.

_____

_____

Have others expressed concern about your child's alcohol or drug use	☐ Yes	☐ No
Has your child been in legal trouble due to alcohol or drug use	☐ Yes	☐ No
Have any family members had difficulty with alcohol or drugs	☐ Yes	☐ No

With alcohol and drug use, have you recently noticed in your adolescent:

Change in peers	☐ Yes	☐ No	Mood swings	☐ Yes	☐ No
Relationship problems	☐ Yes	☐ No	Emotional issues	☐ Yes	☐ No
School issues	☐ Yes	☐ No	Stealing from family/ friends	☐ Yes	☐ No
Work problems	☐ Yes	☐ No	Increased frequency/ quantity	☐ Yes	☐ No

LEGAL ISSUES

Has your child had involvement with the legal system	☐ Yes	☐ No
Any legal problems with other family members	☐ Yes	☐ No

Please explain

_____

CULTURAL AND SPIRITUAL ISSUES

What are the cultural, ethnic, and racial issues that need special consideration?

_____

_____

What are the religious and spiritual issues for consideration?

_____

_____

Is there anything else your counselor should know about your child?

_____

_____

_____ _____

Custodial Parent Signature Date

_____ _____

Reviewed/Updated by Clinician Date

Statement of Understanding
Client's Rights and Responsibilities

TriHealth EAP

What does TriHealth EAP provide?

TriHealth EAP provides counseling services at no cost to you. Specifically, TriHealth EAP provides assessment, short-term counseling when appropriate, referral when needed, and follow-up. When a problem requires specialized or longer-term services, a referral will be made following the assessment of your situation. If you are referred, there may be fees involved for the specialized or long-term services. Those services may be covered under the medical benefits plan provided by your employer; however, it is your responsibility to determine whether the services are covered by the plan.

What does a referral involve?

When a referral is advised, your counselor will work with you to find an appropriate resource. We find it is in your best interest to make the referral at the earliest possible point so you can start working immediately with the appropriate treatment provider. The referral usually takes place after the first or second session with the TriHealth EAP counselor.

Is TriHealth EAP counseling confidential?

No information regarding you or your problem can be released to anyone without your express written consent. If you request we contact someone on your behalf, you must complete an informed consent release. State and federal laws, however, mandate in cases of child abuse, elderly abuse, or when a person may be a threat to their own or someone else's safety, the counselor must notify the proper authorities. TriHealth EAP must also release records if ordered to do so by a court of law. TriHealth EAP complies with State and Federal Law including CFR42 and the Health Information Portability and Accountability Act (HIPAA).

What are the counselor's responsibilities?

Your counselor is responsible for defining the problems as fully as possible. This process is started by completing a general history. Through this assessment, the counselor will determine an approach to the problem, be it short-term counseling or a referral. Your counselor will provide you with honest information about the nature of your particular problems and recommend treatment alternatives based on what is most likely the best outcome. The final decision on what to do is up to you.

What are your responsibilities?

The counseling process is most likely to produce results if you are willing to look at your own behavior, are honest, and are willing to act on what is learned in counseling. You are responsible for setting and keeping appointments.

Please provide as much notice as possible if an appointment is going to be missed.

Any appointment not properly cancelled will be considered a "no show" and will be counted towards your EAP benefit. Generally, failure to notify is considered lack of involvement in the counseling process.

Our goal is a positive, helpful experience for you at TriHealth EAP. Feel free to discuss any problems or concerns you have with the counselor or to call 513 891 1627 or 1 800 642 9794. We value your confidence in us and your suggestions to improve our services.

_____ _____

Client Signature Date

_____

Client Name (Please Print)

_____ _____

Reviewed/Updated by Clinician Date

Notice of Privacy Practices

TriHealth EAP

I, _____ (Print Your Name) hereby acknowledge that I have received the Notice of Privacy Practices from TriHealth EAP.

_____ _____

Client Signature Date

(This acknowledgement form will be scanned into the clinical chart)

Consent to Treat a Minor

TriHealth EAP

I _____ custodial parent/legal guardian of

_____Age_____,

authorizes TriHealth EAP to assess and treat my child in an outpatient counseling setting.

I agree to take part in the counseling process as needed, and understand the format of counseling may include any combination of the following: individual sessions with minor child, family sessions, and sessions with the parent(s)/guardian(s).

_____ _____
Custodial Parent /Legal Guardian Signature Date

_____ _____
Witness Date

_____
Relationship