



**Eagles Landing Christian Counseling Center, Inc.**  
**Main Campus**  
**204 W. Campground Road**  
**McDonough, Georgia 30253**  
**770-898-2966**

**Child/Adolescent Intake Form**

**Parent/Guardian Information (Please Print):**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ Pager/Other: \_\_\_\_\_

Calls or e-mail will be discreet; please note any restrictions: \_\_\_\_\_

**Parent/Guardian please complete our Parent/Guardian Intake Information Forms for yourself as we incorporate you as part of your child/adolescent's treatment**

**Child/Adolescent (Patient) Information (Please have Child/Adolescent Complete this portion)**

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Gender: M F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_ Church: \_\_\_\_\_ Active: Y N

Are there cultural issues I should be sensitive to?: Y N Explain: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Performance: Excellent Good Poor

Is this child currently seeing another counselor, psychologist, or psychiatrist? Y N

If yes, Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Has this child ever been in counseling before? Y N

If yes, when and how long? \_\_\_\_\_

Was it helpful? Y N Explain: \_\_\_\_\_

**Child's Medical Information:**

Name of Primary Care Physician/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Rate child's current physical health: Very good Good Average Declining Poor

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent Weight Changes: (lbs) lost: \_\_\_\_\_ gained: \_\_\_\_\_

Were there complications with pregnancy? Y N Explain: \_\_\_\_\_

Were there complications at birth? Y N Explain: \_\_\_\_\_



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Child/Adolescent's Name: \_\_\_\_\_

List all important illnesses, injuries, or disabilities (past or present): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list ALL medication (prescription or over-the-counter that you are taking or have taken in the last six months. (If necessary, use additional page to list ALL medications):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child exercise? Y N      How and how much? \_\_\_\_\_

Does your child consume caffeine, sweets, or junk food? Y N      How much? \_\_\_\_\_

Does your child eat well? Y N      Any changes? \_\_\_\_\_

Does your child sleep well? Y N      Any changes? \_\_\_\_\_

Has your child ever experimented with drugs or alcohol? Y N

Does anyone in your family use drugs or alcohol? (past or present) Y N

Who lives in your home?

	Name	Relationship to Child	Age	Gender
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

Note other significant relationships (step-parents, step-siblings, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

**Checklist of Concerns: (Check all that apply to any family member and indicate to whom it applies)**

- Abuse (Emotional)
- Abuse (Physical)
- Abuse (Sexual)
- Abuse (Verbal)
- Abuse (Other)
- Anger/Temper
- Anxiety
- Attention, Concentration, distractibility
- Bedwetting
- Communication
- Confusion
- Compulsions (specify \_\_\_\_\_)
- Cruelty to animals



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Child/Adolescent's Name: \_\_\_\_\_

- Death of someone close (or a pet)
- Decision making/indecision
- Developmental Delays (specify \_\_\_\_\_)
- Depression, sadness, low mood, crying
- Emptiness
- Extended family issues
- Fear of failure
- Fatigue, low energy
- Fearfulness, phobias (specify \_\_\_\_\_)
- Financial stress in the home
- Fire setting
- Friendships/Social relationships
- Grieving a loss (specify \_\_\_\_\_)
- Guilt
- Hallucinations/Delusions
- Headaches
- Health, Illness, Medical concerns, Physical Problems
- Hopelessness
- Chores – Quality, Schedules, Sharing Duties
- Inferiority feelings
- Impulsivity, loss of control, outbursts
- Irresponsibility
- Judgment problems
- Legal matters, charges, suits
- Loneliness
- Low frustration tolerance
- Memory problems
- Menstrual problems/PMS
- Mood swings
- Motivation/laziness
- Natural Disasters (tornado, flooding, fire, etc.)
- Neglect issues
- Obsessions/Compulsions (specify \_\_\_\_\_)
- Oversensitivity to criticism
- Panic attacks
- Perfectionism
- Pessimism
- Poor hygiene, poor self-care
- Procrastination/work inhibitions
- Self-centeredness
- Self-esteem
- Self-mutilation
- Sexual issues (specify \_\_\_\_\_)
- Shyness
- Sleep problems (nightmares, night terrors, waking at night, difficulty going to sleep)
- Spiritual concerns
- Stress
- Suspiciousness
- Suicidal thoughts/plan/attempt
- Threatens to harm people, property, animals
- Trauma
- Violence
- Withdrawal/Isolation



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Summary of the reason your child/adolescent is coming to counseling:

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## **Eagle's Landing Christian Counseling Center Financial Policy and Agreement for Professional Services**

Thank you for choosing **Eagle's Landing Christian Counseling Center** as your biblically-based therapeutic provider. We are committed to the success of your treatment. We are a non-profit organization. While keeping fees as low as possible, our counselors still need to be reimbursed for their services. Lower cost consultation is available from time to time with our interns. Below you will find the details of our financial policy. A signed agreement to this policy is required before beginning treatment.

### **1-A. GENERAL FINANCIAL POLICIES FOR ALL CLIENTS:**

- Payments are due at the time of service. Please pay the receptionist or service provider before your meeting.
- We accept payment by cash, check, Visa & MasterCard.
- A \$30.00 fee is charged for any checks returned from the bank for *any* reason and is due in cash at your next session.
- We do not offer delayed billing.
- If you are using an insurance company that we accept, we will bill your insurance company for you. Clients are responsible for all payments, including co-pays, at the front desk, before seeing their counselor. In order to maintain standing appointments, your account must remain current.
- All checks should be made payable to: Eagle's Landing Christian Counseling Center, or ELCC.
- Sessions are 45 – 50 minutes long. A session lasting 1 ½ hours long is considered 2 sessions.
- Phone conversations that exceed 20 minutes in length are charged a one-session fee.
- Note: (A) I understand that fee arrangements are based on my current household income, and that should my financial situation change, I will notify my therapist and understand that fees may be adjusted accordingly.
- (B) I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him/her, either in person or by certified mail, that I wish to terminate.

### **1-B. MISSED OR CANCELLED APPOINTMENTS:**

- Please help us better serve you by keeping scheduled appointments. If you are not going to keep your appointment, please allow time for the therapist to offer the appointment to someone else.
- A \$25.00 fee will be charged for all missed or canceled appointments that are not canceled 24 hours in advance. Payment of the \$25.00 fee must be made at the next appointment.



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- Exceptions will be made in the event of an accident or an emergency [i.e., breaking down, sudden illness, or sudden illness of a minor child, etc. Please note that “having to work” is not considered an emergency.]
- If you, or a family member, pay for a session in advance that you subsequently do not use, you will **not** receive a refund.

**1-C. LATE ARRIVALS OF CLIENTS AND/OR THERAPIST RUNNING LATE:**

- We understand that sometimes things happen and you may arrive late for your appointment. We will do our best to give you your full 45-50 minutes session as long as it doesn't cut into the next clients time. Please understand that we try to stay on schedule as much as possible. By the same token, we are counselors dealing with people and their feelings and occasionally we have urgent situations. Therefore, sometimes we may run late. It is the counselor's prerogative to reschedule you or to continue to run behind by taking some of the next scheduled session to give you your 45-50 minutes. If you choose to leave before 30 minutes of your session time has passed, you are still expected to pay for the session. Please understand that we do our best to treat people as **people, not appointments**. Please respect our counselors by understanding that they are **people too**.

**1-D. MINORS RECEIVING TREATMENT:**

- The parent/guardian(s) is responsible for payment at the time of service. We will not bill parents or others for a minor's session.
- No minor can be treated without signed consent of a parent or guardian.
- Unaccompanied minors will be denied services (except in the case of an emergency) Parent/guardian must be in the office while minor is being treated.
- Parents are expected to be involved with treatment of a minor. If a parent or guardian is unwilling or unable to participate, parent must consult with therapist before minor begins treatment. (*Note: Additional fees may apply*)

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## **Informed Consent**

**Please Read Each Item Listed Below And Initial Each Indicating Agreement:**

- \_\_\_\_\_ 1. I will maintain the confidentiality of anyone I see in the counseling office.
  
- \_\_\_\_\_ 2. I agree to conduct myself in an appropriate manner. Children must be attended at all times.
  
- \_\_\_\_\_ 3. I agree to cancel appointments 24 hours in advance. I understand that I will be charged the normal fee for missed appointments or those cancelled in less than 24 hours, except emergency situations.
  
- \_\_\_\_\_ 4. I understand that physical abuse, sexual abuse, or neglect of children, (under 18 years of age) must be reported by law.
  
- \_\_\_\_\_ 5. I understand that physical abuse, sexual abuse, or neglect of the elderly (65 years and over) must be reported by law.
  
- \_\_\_\_\_ 6. I understand that intent to do harm to another person must be reported to that person and the police.
  
- \_\_\_\_\_ 7. I understand that individual session lengths are 45-50 minutes.
  
- \_\_\_\_\_ 8. I agree to discuss issues only during designated appointments and not during church activities, or during the therapist's personal time. If I have an emergency, I understand that I may notify my therapist.
  
- \_\_\_\_\_ 9. I understand that no information about me or my issues will be disclosed to anyone outside of the Pastoral Care Ministry. However, I do understand that my case will be discussed with other Pastoral Care Counselors for the purposes of supervision and training. Information will be discussed without my name being given.





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Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, hereby consent to the use or disclosure of my protected health information by the practice of Eagle’s Landing Christian Center, hereinafter referred to as “ELCCC” for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by ELCCC may be conditioned upon my consent as evidenced by my signature on this document.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding to the practice and ELCCC.

I have the right to revoke this consent, at any time, in writing, except to the extent that ELCCC or the practice has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by ELCCC, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice’s Notice of Privacy Practices, which has been provided to me by the practice, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the practice’s duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 204 W. Campground Rd. McDonough, GA 30233. As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Personal Representative:

\_\_\_\_\_  
Description of Personal Representative’s Authority

\_\_\_\_\_  
Date