Transition Counseling Services, LLC • Janna Cash Gilner, MA, LPC
10925 Antioch Rd, Suite 205 • Overland Park, KS • 66210 • Phone: 913-904-6855 • www.jannacash.com

CHILD INTAKE INFORMATION

Client Child's Name: _____
(First) (Middle Initial) (Last)

Date of Birth: _____ / _____ / _____ Age: _____ Sex: ❒ Male ❒ Female

Home Address: _____
(Street and Number) (City) (State) (Zip)

Person Completing These Forms: ❒ Mother ❒ Father ❒ Other: _____

Name of Person Completing These Forms: _____
(First) (Middle Initial) (Last)

CONTACT AUTHORIZATION

Messages

Please Call: ❒ My Home ❒ My Cell ❒ My Work Number: _____

If unable to reach me: ❒ you may leave a detailed message, as this is a private line
❒ please leave a message asking me to return your call
❒ do not leave a message

The best time to reach me is (day/s) _____ between (time/s) _____

May I email you?* ❒ Yes ❒ No E-mail: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact

❒ In case of emergency, contact: (name) _____

(phone #) _____ (relationship) _____

I authorize Janna Cash Gilner/Transition Counseling Services, LLC to waive my confidentiality and contact the above named person, if she deems an emergency exists. This person will be notified of the client's location, condition, and acknowledgment as a client of Janna Cash Gilner/Transition Counseling Services, LLC.

A signature is required to confirm and authorize your preferences listed on this form and consent regarding contacting your referral, how you are contacted, and for whom you have named as your emergency contact.

Signature: _____ Date: _____

REFERRAL SOURCE

Name of referral source, or how you heard about Janna Cash Gilner/Transition Counseling Services, LLC:

_____

May I send your referral a thank you? ❒ Yes ❒ No

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BRIEF PERSONAL HISTORY OF CHILD

Ethnic Group: ❒ Caucasian ❒ African American ❒ Latino ❒ Asian American ❒ Native American
❒ Other: _____

School: _____

Current Grade Level: _____ Repeated Grade Level(s): _____

Religion: _____

Child lives with: ❒ both parents (parents live together)
❒ mother (how often: _____)
❒ father (how often: _____)
❒ state custody
❒ foster care
❒ other: _____

Coordination of Care:
Please check any previous or current involvement with any of the following services for your child:

❒ Private Practitioner
❒ Community Mental Health
❒ Medical Hospital
❒ Inpatient Psychiatric Treatment
❒ Department of Family Services (DFS MO)
❒ Department for Children & Families (DCF KS)
❒ Juvenile Court
❒ Other: _____

Please list any *previous* counseling or mental health services (psychotherapy, psychiatric, hospitalizations, etc.). Include the provider's name, type of service, reason for service, city, diagnosis (if any), and date(s) of services:

_____

_____

If in therapy before, what caused you to stop taking your child to that provider, or specifically, what were you looking for that you did not receive:

_____

_____

Please list any *current* mental health providers (psychiatrist, therapist, etc):

_____

_____

Is your child prescribed medication? ❒ Yes ❒ No If yes, list here and include condition or diagnosis:

_____

_____

Please list any *current* medical conditions that receive treatment or medication(s) and Physician's name:

_____

_____

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FAMILY HISTORY

Parent(s)/Guardian(s):

Name: ______________________________________
Age:________ Occupation: ___________________
Relationship (check two):
❒ Mother ❒ Father ❒ Other: ___________________
❒ Adoptive ❒ Biological ❒ Foster ❒ Step

Name: ______________________________________
Age:________ Occupation: ___________________
Relationship (check two):
❒ Mother ❒ Father ❒ Other: ___________________
❒ Adoptive ❒ Biological ❒ Foster ❒ Step

Name: ______________________________________
Age:________ Occupation: ___________________
Relationship (check two):
❒ Mother ❒ Father ❒ Other: ___________________
❒ Adoptive ❒ Biological ❒ Foster ❒ Step

Name: ______________________________________
Age:________ Occupation: ___________________
Relationship (check two):
❒ Mother ❒ Father ❒ Other: ___________________
❒ Adoptive ❒ Biological ❒ Foster ❒ Step

Please check the statements which best describes your parenting:

Mother/Female Caregiver:

	Never	Sometimes	A Lot
Too Strict	❒	❒	❒
Too Busy	❒	❒	❒
Too Lenient	❒	❒	❒
Too Demanding	❒	❒	❒
Too Kind	❒	❒	❒
Too Easy-Going	❒	❒	❒
Too Short-Tempered	❒	❒	❒
Too Severe	❒	❒	❒
Too Nurturing	❒	❒	❒

Father/Male Caregiver:

	Never	Sometimes	A Lot
Too Strict	❒	❒	❒
Too Busy	❒	❒	❒
Too Lenient	❒	❒	❒
Too Demanding	❒	❒	❒
Too Kind	❒	❒	❒
Too Easy-Going	❒	❒	❒
Too Short-Tempered	❒	❒	❒
Too Severe	❒	❒	❒
Too Nurturing	❒	❒	❒

Relationship status of biological parents of child (check all appropriate spaces):
❒ Divorced ❒ Living Together ❒ Father Remarried
❒ Domestic Partnership ❒ Married ❒ Separated
❒ Engaged ❒ Never Married ❒ Widowed: ___________________
❒ Living Separately ❒ Mother Remarried ❒ Other: ______________________

Dates of Marriage: From ___________ to ___________ Number of Years: ___________
Dates of Mother’s Other Marriage(s): From ___________ to ___________ Number of Years: ___________
Dates of Father’s Other Marriage(s): From ___________ to ___________ Number of Years: ___________

Siblings: (Please list all siblings, living and deceased (including client) in order of birth:)

Name	Age	Birth Date	Gender	Grade	Date of Death
1.					
2.					
3.					
4.					

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FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to the child (father, grandmother, uncle, etc).

❒ Over Activity	❒ Suicide Attempts	❒ Explosive Anger
❒ Drug Abuse	❒ Legal Problems	❒ Eating Disorders
❒ Marital Problems	❒ Developmental Disability	❒ Obsessive Compulsive Behavior
❒ Domestic Violence	❒ Emotional Problems	❒ Bipolar Disorder
❒ Alcoholism	❒ Significant Loss	❒ Schizophrenia
❒ Learning Problems	❒ Anxiety	❒ Schizoaffective Disorder
❒ Suicide	❒ Depression	❒ Delusions/Paranoia

❒ Any other significant family history:

_____

_____

HISTORY OF CONCERNS/GOALS

My reason for seeking counseling for my child:

_____

_____

Describe your child's difficulty/struggle and for how long it has been an issue:

_____

_____

Is there a history of similar problems in the family? If yes, please describe.

_____

_____

If not noted elsewhere, please add any worries/concerns you have about your child's therapy services.

_____

_____

What changes are you hoping for?

_____

_____

I will know that my child's goals have been reached, when the following things have changed for the better:

_____

_____

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PARENT ASSESSMENT

Indicate with a checkmark any behaviors your child has.	Never	Sometimes	A Lot
Picks at things (nails, fingers, hair, clothing).			
Sucks or chews (thumb, clothing, blankets).			
Problems with making or keeping friends.			
Excitable, impulsive.			
Cries easily or often.			
Daydreams (mind wanders, imaginary companions, lost in thought).			
Fearful (of new situations, new people or places, going to school			
Restless, always up and on the go.			
Destructive.			
Difficulty in learning.			
Mood changes quickly and drastically.			
Tells lies or stories that aren't true.			
Gets into more trouble than other same age.			
Speaks differently (baby talk, stuttering, hard to understand).			
Denies mistakes or blames others			
Worries more than others (about being alone, illness, or death)			
Fails to finish things.			
Feelings easily hurt.			
Bullies others.			
Childish or immature			
Distractibility or attention span problem.			
Doesn't like doesn't follow rules or restrictions.			
Fights constantly.			
Lets self be pushed around.			
Hurts self (bangs head, biting, holds breath).			
Quiet and withdrawn.			
Bowel problems (frequently loose, irregular habits, constipation).			
Other: _____			

Client's Strengths:

- ❒ Verbal
- ❒ Stable at School
- ❒ High Self-Esteem
- ❒ Support from Family
- ❒ Social Support
- ❒ Other: _____

Please make any comments that may be helpful in understanding your child. You may include any thoughts about both challenges and strengths. (Please use back if needed).

_____

_____

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INFORMED CONSENT & COUNSELING AGREEMENT

Signatures below indicate that you have received, read, and understand the practice policies of Janna Cash Gilner/Transition Counseling Services, LLC, and agree to abide by the outlined policies.

AUTHORIZATION AND CONSENT TO TREAT MINOR CHILD

Custodial Parent(s)/Legal Guardian(s) (of child under 18 years old):

_____ _____

(First) (Middle Initial) (Last) (First) (Middle Initial) (Last)

I voluntarily give consent for my child to receive services provided by Janna Cash Gilner, which may include assessment and referral recommendations as deemed necessary. I understand that during treatment, things may, at times, seem worse before they get better. Sometimes relationships with family/friends may change as a result of thinking and behaving differently, and this may cause stress. As changes take place, there are shifts in various parts of a person's life. I understand that this is part of the change process and I consent for treatment.

By signing below, I warrant that I am a custodial parent or legal guardian of the above named minor child and have legal authority to consent for services. I hereby give permission for him/her to receive therapy. I will assume responsibility to notify my child's other parent that therapy has been initiated.

_____ _____ _____ _____

Legal Custodial Parent/Guardian Signature Date Legal Custodial Parent/Guardian Signature Date

FINANCIAL POLICIES

Clinical Fees: The fee for any child session or parent meeting is $80 and is due at the beginning of each appointment. The length of child sessions may vary depending on the age or needs of a child. Generally sessions are scheduled at 30 or 45-minute lengths. Additional 15 or 30-minutes are used to prepare or clean-up after child sessions and/or to address any needs for outside collaboration with other environments which may inform the therapeutic process. Any phone conversation, between sessions, lasting longer than 15 minutes, will be billed as a session. Forms of payment accepted are cash, check, or credit card. Regardless of payment choice, a current credit card must be kept on file. Receipts are available by request. Occasionally, there are extra or altered charges. In your case, the fee per session will be $_____.

Cancellation Policy: Appointments canceled with less than 24-hour notice will be charged $40. A $40 fee will also be charged if you do not show to a scheduled appointment without notice. Appointments missed due to inclement weather or other major problems will not be charged.

Insurance: I do not accept insurance payment and do not bill insurance companies directly. Your counseling services may be eligible for reimbursement through out-of-network benefits. If you choose to seek reimbursement, it is your responsibility to contact your insurance provider to inquire about reimbursement for out-of-network counseling services. I can provide you with a receipt at the end of each session, which you can submit to your insurance company for out-of-network coverage/reimbursement. You are responsible for filing claims.

_____ _____ _____ _____

Legal Custodial Parent/Guardian Signature Date Legal Custodial Parent/Guardian Signature Date

CLINICAL EMERGENCIES

In the event of an emergency or emotional crisis, and you are unable to reach me by phone, or I am out of town, then you are directed to call 911 or go to your nearest hospital emergency room. Once you are safe, you are directed to contact me.

_____ _____ _____ _____

Legal Custodial Parent/Guardian Signature Date Legal Custodial Parent/Guardian Signature Date

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. State law and professional code of ethics mandate exceptions. Noted exceptions are as follows.

- Duty to Warn – When a client discloses intentions or a plan to harm another person, the counselor is required to warn the intended victim and report this information to legal authorities.
- Duty to Protect – In cases in which the client discloses or implies a plan for suicide, the professional counselor is required to notify legal authorities and make reasonable attempts to notify the emergency contact, family, or a friend of the client.
- Abuse of Children or Dependent/Vulnerable Adults – If an adult client or parent/guardian states or suggests that he/she is abusing a child (or dependent/vulnerable adult), has recently abused a child (or dependent/vulnerable adult), or a child (or dependent/vulnerable adult), is in danger of abuse, the professional counselor is required to report this information to the appropriate social service and/or legal authorities. This also applies in cases where the client is the minor child (or dependent/vulnerable adult) who discloses or suggests that he or she has been abused or is in danger of abuse. The counselor is also required to report reasonable suspicion of abuse.
- Prenatal Exposure to Controlled Substances – Professional Counselors are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- Minors/Guardianship – Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
- Court Proceedings – If you are involved in a court proceeding, your Professional Counselor will not release information without the written authorization of you or your legally appointed representative, or a court order.

The following are noted exceptions within policy of Janna Cash Gilner/Transition Counseling Services, LLC:

- Insurance Providers (when applicable) – Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.
- Written Request for Release of Information – You may complete a form which requests a Professional Counselor to disclose information regarding your records to a third party.
- Crime Committed Against Staff or Property – In cases of crime, this professional counselor reserves the right to disclose names to authorities if charges are required.
- Legal Disputes – If a client makes claims against the professional counselor, the counselor will be required to disclose information about the client that is pertinent to the counselor's defense.
- Unpaid Balance – Should the client accrue unpaid balances which require creditors, the professional counselor will disclose information required to collect balances due.

You must check the statements below and a signature is required.

❒ I agree to the above limits of confidentiality and understand their meanings and ramifications.

❒ I also confirm that I have been given access to a copy of my HIPPA Authorizations and Client Rights.

_____ _____ _____ _____

Legal Custodial Parent/Guardian Signature Date Legal Custodial Parent/Guardian Signature Date

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QUALIFICATIONS

Janna Cash Gilner, MA, LPC:

- Has a Masters in Counseling.
- Is licensed in the State of Kansas as a Licensed Professional Counselor.
- Adheres to the Code of Ethics set forth by the American Counseling Association.
- Has received a Certificate in Play Therapy.
- Cannot prescribe medication.
- Does not provide medical or legal advice.

SUPERVISION NOTIFICATION & AUTHORIZATION

Janna is under supervision seeking advanced licensure to become a Licensed Clinical Professional Counselor. Janna is providing counseling services under the supervision of Melanie L. Davis, PhD, Licensed Psychologist.

Melanie Davis, PhD, Licensed Psychologist
8012 State Line Road, Suite 102
Prairie Village, KS 66208
Phone: 913-461-4610
Website: www.drmelaniedavis.com

This requires you consent to the use of audio or video recordings, case consultation, live consultation, or observation via remote video for the purposes of supervision, and access to your client file. All areas of supervision are treated with the same ethical concern as confidential records and any recordings are erased following supervisory use and are not a part of the client file.

_____ _____ _____ _____
Legal Custodial Parent/Guardian Signature Date Legal Custodial Parent/Guardian Signature Date

WAIVER OF MEDICAL/PSYCHIATRIC CONSULTATION

I understand that under the provisions of Kansas Law, KSA 65-6404 (b) (3), my counselor is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that is causing or contributing to any observed symptoms of a mental disorder in either myself or my child(ren) listed below:

Print Name(s) of Adult(s) and/or Minor Child(ren)

_____

_____

In the event that I or my minor child(ren) do not have a primary care physician or psychiatrist, I acknowledge that my counselor has recommended that I seek medical consultation.

By signing below I am indicating that I waive my right to such consultation and that I do not wish for my counselor to contact my(our) physicians(s). I am also aware that this waiver will become part of my client record.

_____ _____ _____ _____
Legal Custodial Parent/Guardian Signature Date Legal Custodial Parent/Guardian Signature Date

If I choose not to waive this consultation by signing this form, my counselor will request that I complete a separate Release of Information form in order to complete the above-mentioned consultation.

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CREDIT/DEBIT CARD CHARGE AUTHORIZATION

Regardless of payment choice, a current credit card must be kept on file.

Forms of payment accepted: cash, check, or credit/debit card (Visa, MasterCard, American Express, Discover).

My signature below authorizes Janna Cash Gilner, MA, LPC/Transition Counseling Services, LLC to charge my credit/debit card for late cancellation or no show fees and unpaid balances due.

Fees:

- $80 per session
- $40 for late cancellation or no show

CLIENT'S NAME: _____

CARD TYPE: ❒ VISA ❒ MASTERCARD ❒ AMERICAN EXPRESS ❒ DISCOVER

PRINT NAME AS IT APPEARS ON THE CARD: _____

BILLING ADDRESS: _____

_____

CARD #: _____

EXP. DATE: _____ 3-DIGIT SECURITY CODE: _____

CARDHOLDER'S SIGNATURE: _____

DATE: _____