Breaking Free, LLC
COUNSELING SERVICES

Welcome to Breaking Free, LLC Counseling. Thank you for selecting our facility for your mental health needs. Our mission is to provide a compassionate experience to help individuals get through the struggles and obstacles they come across throughout life.

Any discussions with our therapists are confidential and are protected by HIPPA (Health Insurance Portability & Accountability act). We do not release any information without written consent by our clients, unless mandated by law.

Please complete all forms in this packet and bring to your first appointment. Unfortunately, if paperwork is incomplete, we will have to reschedule your appointment.

If you need to cancel or reschedule your appointments, we ask for you to give us a 24-hour notice in advance or before 4PM the day prior of your appointment, so we can provide care to other individuals who are waiting.

In case of an emergency, please go to your nearest emergency room or call the crisis hotline at: 800-560-5535

We look forward to meeting with you and providing the highest quality of care!

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PATIENT INFORMATION

NAME _____ **M F** **Birthday** / /

Address _____

Home# - - **Cell#:** - - **SS#** - -

Parents name: (for minors only) _____

Employer: _____ **Work#** - -

Emergency Contact/Relation: _____ **Phone** - -

Primary Care Doctor: _____

INSURANCE INFORMATION

You are required to provide accurate information, or you could be responsible for 100% of billings, if you have a secondary insurance then it must be coordinated with your primary. You are responsible to inform Breaking Free LLC of any changes in insurance.

Primary Insurance: _____ ID# _____

Group# _____ Subscriber: _____

Address: _____ DOB: / /

Secondary: _____ ID# _____

Group# _____ Subscriber: _____

Address: _____ DOB: / /

EMPLOYEE ASSISTANT PROGRAM (EAP)

Name of program: _____ Auth# _____

Our services are billed to your insurance as a courtesy, provided all information is given to us at time of service. Any outstanding accounts (more than 90 days) will be sent to collections unless an agreement has been made for payment arrangements with the Office Manager. If your account it sent to collections, you will be billed an extra $65.00 processing fee. Any No Shows/Late Cancellations will be billed to the responsible party and are not covered by insurance. *See no show/late cancellation policy. Payments are due on the 15th of the month. Late payments could incur a 15.00 late charge.*

Print name of responsible Party**:** _____

Signature: **Date** / /

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No Show-Late Cancellation Policy

Our provider's time is very valuable, and it is the sole responsibility of the client or representative to call 24 hours in advance to reschedule or cancel appointments.

If we do not hear from you regarding your scheduled appointment and you do not call our office to cancel or reschedule with advanced 24-hour time frame, you could be charged up to $155.00. **This charge is not billable to your insurance.**

We have a confidential voicemail that is time stamped, so if you need to make changes regarding your appointment, please leave a message with your name, time of your appointment and the reason you are cancelling.

If you are billed for a late cancellation or no-show appointment and you fail to pay or make payment arrangements, this could impact the ability to receive services you require from your counselor.

Any client failing to cancel their appointment in a timely manner, or no show more than two appointments may receive a discontinuation of services letter due to the lack of participation in your treatment.

You deserve quality care, so we would like to take this opportunity to thank you for choosing Breaking Free, LLC counseling services.

Print Name: _____

Signature:_____

DATE:_____/_____/_____

Breaking Free, LLC
COUNSELING SERVICES

Release of Information

This is NOT a records release

If you wish to have anyone act on your behalf as far as scheduling, billing or verbal communication with your Counselor or office staff, please indicate below their name and relationship to you and what they are authorized for. If you choose not to have anyone act on your behalf, please write "no one" in the space provided below. Any client 14 years or older shall sign this form, clients 13 and under must be signed by legal guardian.

Name & Relationships to Client:

_____

_____

_____

_____

I also understand that I may revoke this release **in writing** at any time, except for action already taken. By signing and dating this release, you accept this authorization for office staff and/or your counselor to communicate with others indicated above for 12 months or 90 days after the last face to face contact, whichever is later.

It is Breaking Free LLC's right and mandated responsibility to report at risk behavior for self-harm or the harm to others.

SIGN: (Client's 14 and up) _____

SIGN: (Legal guardian 13 and younger) _____

DATE:_____/_____/_____

Breaking Free, LLC
COUNSELING SERVICES

Privacy Policy

I authorize Breaking Free, LLC to disclose the health and clinical information only for treatment, payment and health care operations. Breaking Free LLC is not liable for any internet security breaches for online counseling. Our Tele-Therapy uses a secure platform called Doxy.me however Breaking Free LLC is not liable for any internet breaches.

Assessments and progress notes are subject to the supervision review by Vicki North, Clinical Supervisor, at Breaking Free LLC. Some treatments by an intern, may be billed under the licensed clinicians name.

Health Care: Breaking Free, LLC may disclose necessary health information for administration and business purposes.

Payment: Breaking Free, LLC may disclose limited health and demographic information for obtaining eligibility and claim processing.

Treatment: Breaking Free, LLC may use your health care information to provide clinical services to other personnel that are involved in your treatment.

Assessments and progress notes are subject to the supervision review by Vicki North, Clinical Supervisor, at Breaking Free LLC. Some treatments by an intern, may be billed under the licensed clinicians name.

I understand that my health information is confidential and cannot be released for other than those listed above, without written my consent, unless mandated by law. I may revoke the consent at any time if I do so in writing, except to the extent Breaking Free, LLC has already used or disclosed on reliance of this signed consent.

Print Name of Client: _____

Clients Signature: (or person authorized by law to act on behalf of client)

Please Sign: _____

Date: ____/_____/_____

Breaking Free, LLC
COUNSELING SERVICES

Consent for Treatment

By signing this form, you voluntary agree to receive mental health services from Breaking Free, LLC, counseling for any such care, treatment and/or services that are considered advisable and necessary.

In the event that services are no longer needed, or my therapist is no longer practicing, I understand that my records will remain at Breaking Free LLC until I authorize in writing to deliver said records to any therapist or facility of my choice.

I understand and agree to participate in the planning of my treatment and may stop services and/or treatment at any time.

I acknowledge by signing this form that I have read and understand the terms contained herein.

I also consent that Breaking Free LLC may communicate with me by phone, email or mail.

Client name: (print)_____

Client/Parent/Guardian: (signature)_____

Date: ____/_____/_____

Breaking Free, LLC
COUNSELING SERVICES

Child Intake Questionnaire

(To be completed by Parent/Guardian)

Your Name: _____ Date completed ____/___/____

Name of child_____

Child's Date of Birth ____/____/_____ Childs Age _____ Child's Gender _____

Your relationship to child _____

Referred by _____

What are your hopes regarding your child's therapy?_____

_____

_____

_____

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? (e.g., illness, deaths, operations, accidents, separations/divorce of parents, parent changing job, child changing schools, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No

If yes, please describe:_____

_____

_____

Your Child's Symptoms or Problems

How much are each of the following areas currently a problem for your child?

	Not at all	**A little**	**Somewhat**	**Considerably**	**Terribly**
	1	**2**	**3**	**4**	**5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5

Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Please rate the following items that occur for your child:
0=None, 1=Mild, 2=Moderate, 3=Severe

A----------

___ Has a hard time giving close attention to details
___ Makes careless mistakes in schoolwork or work
___Doesn't seem to listen when spoken to
___Doesn't follow through on instructions
___Fails to finish school work or chores
___Has difficulty organizing tasks and activities
___Avoids or doesn't like homework
___Loses things often
___Is easily distracted
___Is forgetful in daily activities
___Fidgets with hands or feet or squirms in seat
___Difficulty staying seated
___Often talks excessively
___Often shows feelings of restlessness
___Often "on the go" with excessive energy
___Often blurts out answers
___Has difficulty awaiting turns
___Often interrupts or intrudes on others

B----------

___Often loses tempter
___Often argues with adults
___Often actively defies or refuses to comply with adults' requests or rules
___Often deliberately annoys people
___Often blames others for his/her mistakes or misbehavior
___Often easily annoyed by others

___Often angry and resentful
___Often spiteful or vindictive

C----------
___Repeated passage of feces in inappropriate places (clothing or floor)
D----------
___Repeated urinating in bed or clothes (whether involuntary or intentional)
E----------
___Overly upset when separated or thinks about being separated from home or parent(s)
___Worries about losing or about possible harm coming to parent(s)
___Worries about getting lost or kidnapped
___Refuses to go to school or elsewhere because of fear of separation
___Is afraid to be alone or without parent
___Often refuses to go to sleep without being near parent(s)
___Repeated nightmares involving the theme of separation
___Repeated complaints of physical symptoms (such as headaches, stomach aches, or nausea) when separation from parent(s) occurs or is anticipated
F----------
___Sad, depressed, unhappy
___Decreased enjoyment, pleasure, interest
___ Change in weight
___Failure to make expected weight gains
___Sleep problems
___ Irritable, agitated
___Fatigue, loss of energy
___Hopelessness
___Guilt feelings
___Difficulty concentrating, indecisiveness
___Suicidal verbalizations, thoughts
___Social withdrawal ___physically ___verbally
___Anxious, nervous, edgy
___Poor appetite or overeating
___Low self-esteem
___Often in an irritable mood
___Often whining or crying
___Few friends, losing friends
___Negative self-statements
___negative statements of thoughts
___Vegetate in front of the TV
G----------
___Inflated self-esteem or grandiosity
___Decreased need for sleep
___More talkative than usual
___Racing thoughts
___Distractible

___Psychomotor agitation
___Mood swings
___Irritable mood
___Overactive, too happy, too busy, elevated mood
___Excessive involvement in pleasurable activities
___Excessive worry about a number of events
___The child finds it difficult to control the worrying
___Feelings of being keyed up or on edge
___Easily fatigued
___Difficulty concentrating or mind going blank
___Irritability
___Muscle tension
___Sleep disturbance

J----------

___Obsessional thought impulses or images that are a produce of the child's mind
___Repetitive behaviors (hand washing, ordering, checking) or mental acts (praying, counting, repeating words silently) that the child feels driven to perform with the aim to prevent or reduce some dreaded event or situation

K----------

___Persistent fear of one or more social or performance situations where the child is afraid that he or she will act in a way that will be humiliating or embarrassing (The fear would include peers as well as adults)
___Anxiety expressed in such situations by crying, tantrums, freezing or shrinking from social situations with unfamiliar people
___The feared social or performance situations are avoided or else are endured with intense anxiety or distress

L----------

___Excessive fear linked to a specific thing (flying, heights, animals, receiving a shot, seeing blood, etc.)
___Exposure to the thing the child is afraid of provokes immediate anxiety such as crying, tantrum, freezing, or clinging
___Child avoids the thing they are afraid of

M----------

___Experiencing periods of time of intense fear with some of the following symptoms (circle all that apply) pounding heart, sweating, trembling or shaking, sensations of shortness of breath, feeling so choking, chest pain, nausea, feeling dizzy, fear of losing control, fear of dying, numbness or tingling sensations, or chills
___Fear is so great the child doesn't want to leave home or being in social situations

N----------

___Has experienced a serious emotional stressor within the last 3 months (divorce, witnessing abuse, abuse, separation from a loved one, moving, problems at school, etc.)
___Emotional distress if out of proportion to the stressful event
___Child has difficulty functioning normally at home or in school

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems): _____

_____

_____

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

_____

_____

_____

Has your child ever been hospitalized for medical or mental illness reasons? If so, list when, where, & reason:

_____

_____

Who is your child's psychiatrist (if applicable)? _____

Please list your child's current prescription medications with dosage (psychiatric and general health):

_____

_____

_____

YOUR CHILD'S FAMILY

Complete parental information for all that	**Biological Mother**	**Adoptive/Step Mother**	**Biological Father**	**Adoptive/Step Father**
Current age, or if deceased date, age, & cause of death				
Country of Origin				
Occupation				
Religious/Spiritual Affiliation?				
Highest grade completed				

Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? _____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:_____

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you?	Any medical, social or academic problems (please list for each)?

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle		List Family Member(s)
Anxiety (general)	Yes	No	
Obsessive Compulsive Behavior	Yes	No	
Depression	Yes	No	
Suicide Attempts	Yes	No	
Bipolar/Manic Depressive	Yes	No	
Alcoholism	Yes	No	
Substance Abuse	Yes	No	
Domestic Violence	Yes	No	
Eating Disorders	Yes	No	
Obesity	Yes	No	
Schizophrenia	Yes	No	
Counseling or Psychotherapy	Yes	No	
Psychiatric Hospitalizations	Yes	No	

Home/Family Life

What are 5 things that you enjoy most about your child? _____

_____

What are some activities you engage in as a family? _____

Does your child participate in any religious or faith-based group? _____

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques? _____

_____

What are your strengths personally and as a parent? _____

What are some of your areas of needed growth? _____

What are your child's strengths (things he/she is good at)? _____

What are your child's areas of needed growth? _____

Social and Community Engagement

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activities is he/she involved? _____

How does your child get along with other children? _____

H----------

___Child has been a victim or has witnessed events that involve events that are outside of normal human experiences (Abuse, domestic violence, natural disaster, death, etc.)
___Child has responded to such event(s) with intense fear, helplessness, or horror
___Disorganized or agitated behavior
___Fear, specify: _____
___Repetitive play with themes in aspects in trauma is expressed
___Recurring nightmares, Theme: _____
___Somatic complaints such as body complaints, stomach pains or headaches
___Overly dependent
___Worries of separation
___Excessive need for reassurance
___Tense/unable to relax
___Feelings of detachment or estrangement from others (like experiences are not real)
___Restricted range or emotions (either sad or angry)
___A general distrust of people
___avoidance of certain people or activities
I----------

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any serious medical problems? _____

_____

_____

_____

Has your child ever been treated for any of the following? If so, please circle and describe: Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions:

_____

_____

_____

Who is your child's primary care physician? _____

When was your child's last complete physical exam (mo/year)? _____

YOUR CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth of the child

Where there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe: _____

Medications used during pregnancy? Please list: _____

Smoking? Yes No How much? _____
Alcohol intake? Yes No How much? _____
Drug intake? Yes No How much? _____
Length of pregnancy?_____Weeks Age of mother at birth: Birth weight: _____
Were there any complications during delivery? If so, please describe: _____

_____

Length of stay in the hospital? Mother:_____(days) Child: _____(days)

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each):

Turn over _____ Crawl _____ Stand Alone_____ Walk Alone _____

First Words _____ First Phrases_____

Toilet trained? Yes No If yes, days?_____Nights? _____

Has your child wet or soiled himself after being trained? Yes No If yes, until what age?__

Enjoyed cuddling? Yes, No Fussy, Irritable? Yes, No

More active than other babies? Yes No

If your child has siblings, was development different in any way? Explain:_____

_____

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? __

School name: _____Public or Private (circle one)?

Street Address: _____

School District/County? _____ Phone: ___(___)_____

What preschool experience did your child have? _____

Where any problems detected in your child's kindergarten screening? Yes No If so, please explain:

_____

Is your child in a regular classroom? Yes No Does your child have an IEP ? Yes No

Has your child ever received tutoring? Yes No If so, please explain: _____

What are your child's typical grades? _____

What are your child's strongest and weakest points academically? _____

_____

Are you satisfied with your child's educational program? Yes No Please explain: _____

_____

Who are some of your child's closest friends (first name) _____

_____

How many times a week does your child exercise? _____What type & how many minutes? _____

What types of food does he/she often eat? _____

Assessment of Risk of Self-Harm or Harm to Others

__Has child been a danger to others? Yes___ No____

__Has child been danger to self: Suicide plan __Suicide Ideation __Access to firearms __Other areas of harm to self or others? (please explain) _____

_____

_____

Do you suspect or know if your child drinks alcohol or uses recreational drugs? If so, what kind &how often? _____

_____

Do you or anyone close to your child consider his/her use to be a problem? Yes No

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: _____

_____

_____

_____