Puckett Counseling Services
Intake Information

Client Name:		Client SS#:			
Address:		Phone Number			
City/State/Zip:		D.O.B.		Race:	
Name of Spouse:		Address:			

If client is a child please complete the following:

Mother's Name: ______________________________ Address: ______________________________

____

Father's Name: ______________________________ Address: ______________________________

____

Contact Information: In the event we need to contact you regarding your appointment, please list only phone numbers we may call to reach you. Below, please check the box of the phone number if we can leave a message with a person or on an answering machine regarding your appointment or other non-personal information.

Email Address: ______________________________

☐ send message to this address ☐ do not send message to this address

Home: ______________	Work: ______________	Cell: ______________
☐ leave message	☐ leave message	☐ leave message
☐ do not leave message	☐ do not leave message	☐ do not leave message

Who referred you to us?: ______________________________

Employer: ______________________________ Occupation: ______________________________

Employer's Address: ______________________________ City/State/Zip: ______________________________

Primary Care Physician (doctor):

Name: ______________________________

Address: ______________________________

City: ______________ State: _____ Zip: __________ Phone: ______________

Marital/Family Information

Current Marital Status ☐ Single (never married) ☐ Engaged ☐ Married ______________ (how long?)
☐ Separated ______________ (when?) ☐ Divorced ______________ (how long?)

Current Marriage (is your): ☐1st ☐2nd ☐3rd ☐4th

How would you rate your current marital relationship? ☐Poor ☐Fair ☐Good ☐Great

Children:

First Name	Age	Sex	In Home	Both	His	Hers
			☐			
			☐			
			☐			
			☐			

Please check if any of the following have recently or are presently a problem for you or your child (if client is a child):

☐ Depression	☐ Trembling/Shaking	☐ Panic Attacks
☐ Anxiety/Nervous	☐ Hopelessness	☐ Loss of Joy for Life
☐ Sleep Disturbance	☐ Low Self-Esteem	☐ Hallucinations
☐ Appetite Disturbance	☐ Irritability	☐ Poor/Decreased Concentration
☐ Fatigue/Low Energy	☐ Anger/Frustration	☐ Frequent Worry
☐ Stress	☐ Thoughts of Suicide	☐ Alcohol/Drug Use
☐ Eating Disorder	Other ______________________________	

Please check if any of the following are current problems or concerns for you or your child (if client is child):

☐ Marital Problems	☐ Financial Problems	☐ Work Problems
☐ Family Relationships	☐ Spirituality	☐ Loss/Death
☐ Dealing with Children	☐ Sexuality	☐ Legal Problems
☐ Divorce	☐ Health Problems	☐ School Problems
☐ Remarriage	☐ Traumatic Event	☐ Sexual Abuse
☐ Childhood Abuse	Other ______________________________	

Treatment/Health History

Rate your current physical health: ☐ Very good ☐ Good ☐ Fair ☐ Poor

List any medications you are taking: ____

Have you ever sought counseling before?: ☐ Yes ☐ No Who? ______________________

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, please list dates/where: ____

What do you hope to gain from counseling? ____

Name: ______________________________ Date: ______________________

Permission for Treatment

By signing below you are providing permission for treatment/services from Puckett Counseling Services. By signing below you are also stating that you have the legal authority to sign for yourself. If you are signing on behalf of another (i.e. child, dependent adult) you are acknowledging that you have the legal authority to provide permission for the individual. In the case of separated/divorced parents, the parent with primary custody must sign for the child; joint custody requires the permission of both parents.

______________________________ ______________________
Signature of Client Date

______________________________ ______________________
Signature of Guardian/Parent Date

______________________________ ______________________
Signature of Witness Date

______________________________ ______________________
Witness (Printed Name) Date

Puckett Counseling Services, LLC

Coordination of Care and Release of Information Form

Communication between your behavioral health provider and your primary care physician, psychiatrist, school counselor, and other professionals invested in your treatment is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any mental health diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. This consent expires in one (1) year from the date of my signature below unless otherwise stated herein.

Puckett Counseling Services, LLC is authorized to release protected health Information related to the evaluation and treatment of:

______________________________ , ______ /______ /_______

(Client Name) (Date of Birth – MM/DD/YYYY)

Release Information To:

Name: ______________________ Phone:_______________

Practice/Specialty: __________________________

Address: ______________________________________

(Street) (City) (State) (Zip Code)

Disclosure may include the following verbal or written information:
(Check all that apply)

__ Psychological evaluation

__ Behavioral health/psychological consult

__ Discharge summary

__ Psychosocial assessment

__ Summary of treatment records & contact dates

__ Other

I hereby give authorization for release of information to the above named party

____

(Signature of Client, Parent, Guardian or Authorized Representative) (Date)

I hereby refuse to give authorization for any release of information

____

(Signature of Client, Parent, Guardian or Authorized Representative) (Date)

Puckett Counseling Services, LLC
Coordination of Care and Release of Information Form (cont.)

I want to inform you that ____ was seen
(Client Name)
by me for the treatment of:
DSM-IV and/or medical diagnosis____

Date(s) of appointment:____

Summary:____

____

____

____

____

____

The treatment plan consists of the following modalities:
___ Individual Psychotherapy ___ Group Psychotherapy ___ Family Psychotherapy
___ Psychological Testing ___ Other (specify)

Estimated length of treatment: ____

If you would like any further contact regarding this case, or if you have further information that you think might assist us in better meeting this individual's clinical needs, please feel free to contact me directly.

____
(Signature of Provider) (Date)

____
(Print Provider Name)

Puckett Counseling Services, LLC
220 N Race St.
Glasgow, KY 42141
270-629-6373

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients.

Puckett Counseling Services

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name: ____________________
Date of Birth: ____________________
Social Security Number: ____________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Puckett Counseling Service's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Peggy Smith-Puckett at 270-791-2178.

Signature of Patient/Client: ____________________ Date: __________
Signature of Parent, Guardian or
Personal Representative*: ____________________ Date: __________
If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.). ____________________
☐ Patient/Client Refuses to Acknowledge Receipt:
Signature of Staff Member: ____________________ Date: __________

Permission to Treat

Client Name: ____________________
Client Date of Birth: ____________________
Client Social Security Number: ____________________
Permission is hereby given to the staff of Puckett Counseling Services to render treatment and/or services to the above named individual whose relationship to me is:

____
I certify that I am legally authorized to grant such permission.
Client or Representative
Signature: ____________________ Date: __________
If Representative Signature
Relationship to Client: ____________________
Witness: ____________________ Date: __________

Consent for Audio/Video Taping

I, ____________________ (print subject's name) hereby authorize Peggy Counseling Services to make a sound and/or visual Recording of me with my awareness. I understand, that before the Recording and if I so wish, to require that my name and other identifying information and/or any other portion of the Record be erased, and further that, subsequent to this opportunity, no other identifying information will be added to the Record. Further, I understand that this Record will not be used for any commercial purposes by Puckett Counseling Services. Finally, I understand that I am free to impose additional restrictions, and that, upon written request, at any time, I may review the Recording and alter the terms of this consent, if I so choose.

Additional Restrictions: * ____________________

____________________ ____________________
Witness not related to client/subject Client/subject signature

____________________ ____________________
Date Signature of parent or legal guardian if subject under 16 years of age.

I, Peggy Smith-Puckett have explained this Consent form to the client/subject. I am satisfied that the subject and/or his or her parent understands this Consent and possesses the capacity to grant the consent.

____________________ ____________________
Date Signature

Child Behavior Checklist

Name of person completing form:		Client Name:	
Date Completed:			

		Frequency	Daily/Weekly/Monthly
	First Column: 0 = Not True (as far as you know) 1= Somewhat or Sometimes True 2 = Very True or Often True		
ACTIVITY Hyperactivity	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Restless (such as squirming in seat):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Impulsive (acts without thinking):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Fidgets (such as hands always busy):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Ticks or unusual activities:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Jokes inappropriately:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Recent inc. in activities: work, sex, social:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Loss of energy or fatigue:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Loss of motivation (no interest in activities):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Bored and uninterested:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
ANXIETY/PHOBIA Nervous or anxious:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Afraid of a lot of things:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Afraid of a specific thing:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Worries often about:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Panic attacks:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Feels disliked or criticized:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Obsessive behaviors (counting, touching, exercising, etc.):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
MOOD Angry:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Grouchy or irritable:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Depressed/sad mood:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Strong guilt feelings:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Feels as if she/he is bad:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Mood swings:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Tearfulness:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Hopeless or helpless:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly

Dislikes self:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Feels unloved or unliked:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Overestimates own abilities:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Elevated mood:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
SLEEP Marked change in sleeping habits:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Difficulty falling asleep:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Wakes up early & can't fall back asleep:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Sleeps too much:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Bad dreams or night terrors:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
APPETITE Binge eating:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Self-induced vomiting:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Loss of appetite:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Increase in appetite:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Weight gain:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Weight loss:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Dislikes own appearance or body size:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Mind/Speech/Thoughts Makes poor decisions:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Difficulty focusing on school work:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Poor problem solving skills:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Difficulty making decisions:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Poor concentration/easily distracted:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Accident prone:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Forgets easily:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Memory loss of significant events:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Does not acknowledge own problems:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Racing thoughts:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Talks excessively:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
THOUGHT CONTENT Grandiosity:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Strange or unusual ideas:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly

	Delusions or false beliefs:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Thoughts of suicide:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Avoids eye contact/direct conversations:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Hallucinations (sees, hears, smells, feels):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Reoccurring thoughts or play of distressing events:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Paranoia (thinks others will injure him/her):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
PHYSICAL	Aches and pains:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Physical complaints (stomach, head, etc.):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Sweaty palms:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Auto or other accidents:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Smells of paint/other chemicals:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Health problems:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Doesn’t give adequate care to hygiene:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Onset of puberty:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Developmental delays:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Growth spurts:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Difficult pregnancy (of mother):	❍ 0 ❍ 1 ❍ 2		
	Prenatal drug use by mother:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Child is sexually active:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Defecating (soiling on self):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Urinating on self:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Bedwetting:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Reoccurring respiratory problems:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Suspect drug or alcohol use:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Tobacco use:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
RELATIONAL	Drop in grades:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Lost job:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
	Legal problems:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly

Theft (in or out of home):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Dishonesty or lying:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Dangerous or risk taking behavior:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Missing or cutting school:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Physically abusive to others:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Conflict with parents or teachers:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Destructive (hits or breaks things):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Threatens to harm or kill others:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Cruel to animals or other children:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Suspensions from school:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Fights with peers or siblings:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Self injurious (cuts, burns, tattoos, etc.):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Threats to kill self:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Suicide attempt:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Blames others for own behavior:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Lonely or difficulty attaching to others:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Poor social skills (difficulty making & keeping friends):	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Defies authority:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Withdrawn from family or friends:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly
Ridiculed by peers:	❍ 0 ❍ 1 ❍ 2	❍ 0-5 ❍ 5-10 ❍ 10-15 ❍ 15-20 ❍ 20-25 ❍ 25-30 ❍ Greater	❍Daily ❍ Weekly ❍ Monthly

Signature of Person Completing Form: ______________________________ Date: ________________

CHILD ATTACHMENT CHECKLIST

Child's Name: ______________________________ Date: ______________
Parent's Name: ______________________________

	SYMPTOMS	NONE	MILD	MODERATE	SEVERE
1	Is unable to give and receive love	0	1 2 3	4 5 6 7	8 9 10
2	Is oppositional, argumentative, defiant	0	1 2 3	4 5 6 7	8 9 10
3	Is emotionally phony, hollow or empty	0	1 2 3	4 5 6 7	8 9 10
4	Is manipulative or controlling	0	1 2 3	4 5 6 7	8 9 10
5	Has frequent or intense angry outbursts	0	1 2 3	4 5 6 7	8 9 10
6	Is an angry child inside	0	1 2 3	4 5 6 7	8 9 10
7	Unable to cry about something sad	0	1 2 3	4 5 6 7	8 9 10
8	Avoids or resists physical closeness and touch	0	1 2 3	4 5 6 7	8 9 10
9	Cannot be trusted	0	1 2 3	4 5 6 7	8 9 10
10	Has little or no conscience	0	1 2 3	4 5 6 7	8 9 10
11	Is superficially engaging and charming	0	1 2 3	4 5 6 7	8 9 10
12	Lack of eye contact on parental terms	0	1 2 3	4 5 6 7	8 9 10
13	Indiscriminately affectionate on parents' terms	0	1 2 3	4 5 6 7	8 9 10
14	Not affectionalte on parents' terms	0	1 2 3	4 5 6 7	8 9 10
15	Destructive to self, others and property	0	1 2 3	4 5 6 7	8 9 10
16	More disobedient toward mom than dad	0	1 2 3	4 5 6 7	8 9 10
17	Cruel to animals	0	1 2 3	4 5 6 7	8 9 10
18	Steals	0	1 2 3	4 5 6 7	8 9 10
19	Lies about the obvious (crazy lying)	0	1 2 3	4 5 6 7	8 9 10
20	Is impulsive or hyperactive	0	1 2 3	4 5 6 7	8 9 10
21	Lacks cause and effect thinking	0	1 2 3	4 5 6 7	8 9 10
22	Gorges or hoards food	0	1 2 3	4 5 6 7	8 9 10
23	Has poor peer relationships	0	1 2 3	4 5 6 7	8 9 10
24	Preoccupation with fire, blood, or violence	0	1 2 3	4 5 6 7	8 9 10
25	Persistent nonsense questions or incessant chatter	0	1 2 3	4 5 6 7	8 9 10
26	Inappropriately demanding and clingy	0	1 2 3	4 5 6 7	8 9 10
27	Sexual acting out	0	1 2 3	4 5 6 7	8 9 10
28	Bossy with peers	0	1 2 3	4 5 6 7	8 9 10

Puckett Counseling Services, LLC

Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization creates, receives, and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that my personal health information may be used and disclosed to your insurance company by this organization and to carry out my care and treatment, to obtain payment and for this organization's health care operations.

The Impact Plus Program shall have the right to interview recipients, parents, guardians, primary caregivers or current or previous provider or subcontractor staff with regard to a service provided within the Impact Plus Program. Access to a provider's or subcontractor's records relating to a service provided shall be made available upon request to:

(i) A representative of the United States Department of Health and Human Services;
(ii) The United States Attorney General's Office;
(iii) The state Attorney General's Office;
(iv) The state Auditor's Office;
(v) The Office of the Inspector General.
(vi) The Kentucky Department of Medicaid Services;
(vii) DMHMRS and DCBS as contractors of services;
(vii) Managed Care Organizations contracted with the Kentucky Department of Medicaid Services.

I have been provided with a copy of this organization's **Notice of Health Information Practices** that provides a more complete description of information about uses and disclosures, and I have had an opportunity to ask questions about anything I did not understand. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices. If it does so, prior to implementation, it will post/provide a copy of any revisions to the **Notice of Health Information Practices** or I may obtain a copy by contacting the Privacy Officer.

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested: however, if it agrees, it is bound by our agreement. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I hereby consent to Puckett Counseling Services using and disclosing my health information for the purposes of my treatment, obtaining payment and for its health care operations.

Patient Name (Printed): ______________________________

Patient's Date of Birth: ______________________________

Signature of Patient or Legal Representative: ______________________________

Name of Legal Representative (Printed)
(if applicable): ______________________________

Signature of Witness: ______________________________

Date: ______________________________

Puckett Counseling Services
Informed Consent

Everything you say in the privacy of our therapeutic session will be kept confidential, but it is important to note that confidentiality is not absolute. There are exceptions to confidentiality, under certain conditions it may be mandated by federal and state law that confidential information about you and/or your treatment be released without your permission. Three of these conditions are as follows:

(1) If it is determined that you are dangerous to yourself and/or to others.

(2) If it is determined or suspected that you are a victim or perpetrator of abuse or neglect.

(3) If I am subpoenaed to court and ordered by the judge to testify about you and/or your treatment. In this instance, I will do everything possible to protect your confidentiality while still complying with the court.

Other exceptions include: (1) you are court-ordered to treatment, (2) you direct me to tell someone through a Release of Information**. It is especially important to remember that your child has a right to confidentiality in therapy and as part of our treatment agreement you agree to not violate the child's right to privacy. As part of our treatment agreement you agree not to have me called as a witness for any court appearance.**

MY SIGNATURE BELOW CONFIRMS THAT I HAVE READ THE ABOVE STATEMENTS AND UNDERSTAND WHAT THEY MEAN AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS OF MY SERVICE PROVIDER REGARDING THIS CONSENT.

Client Name: ____

Social Security Number: _____________________________________

Date of Birth: ____

Signature of Client: ____ Date: __________

Signature of Client's Representative: ____ Date: __________

Signature or Witness: ____ Date: __________

PERSONAL HISTORY

Client's name: ______________________ Date: ____________

Gender: ☐Male ☐Female Date of Birth: ____________ Age: ______ Grade in school: ______

Form completed by (if someone other than client): ______________________

Address: ______________ City: ______________ State: ____ Zip: ________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

If you need more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

☐Anger management ☐Anxiety ☐Coping ☐Depression

☐Eating Disorder ☐Fear/phobias ☐Mental Confusion ☐Sexual concerns

☐Sleeping problems ☐Addictive behaviors ☐Alcohol/drugs ☐Hyperactivity

☐Other mental health concerns (specify):

Family History

Biological Parents

With whom does the child live at this time: ______________________

Are parent's divorced or separated? ______________________

If Yes, who has legal custody? ______________________

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ☐Yes ☐No

If Yes, describe: ______________________

Client's Biological Mother (if unknown mark as unknown)

Name: ______________ Age: ______ Occupation: ______________ ☐FT ☐PT

Where employed: ______________________ Work Phone: ______________

Mother's education: ______________________

Is the child currently living with mother? ☐Yes ☐No

Is there anything notable, unusual or stressful about the child's relationship with the mother? ☐Yes ☐No If yes, please explain: ______________

How is the child disciplined by the mother? ______________________

For what reasons is the child disciplined by the mother? ______________________

Client's Biological Father (if unknown mark as unknown)

Name: ____________________ Age: ______ Occupation: ____________________ ☐FT ☐PT

Where employed: ____________________ Work Phone: ____________________

Father's education: ____________________

Is the child currently living with Father? ☐Yes ☐No

Is there anything notable, unusual or stressful about the child's relationship with the father? ☐Yes ☐No

If yes, please explain: ____________________

How is the child disciplined by the father? ____________________

For what reasons is the child disciplined by the father? ____________________

Client's Biological Siblings and Others Who Live in the Household (if unknown mark as unknown)

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
		☐F ☐M	☐home ☐away	☐poor ☐average ☐good
		☐F ☐M	☐home ☐away	☐poor ☐average ☐good
		☐F ☐M	☐home ☐away	☐poor ☐average ☐good
		☐F ☐M	☐home ☐away	☐poor ☐average ☐good

Others living in the household	Gender	Relationship (cousin, foster child)	Quality of relationship with the client
	☐F ☐M		☐poor ☐average ☐good
	☐F ☐M		☐poor ☐average ☐good
	☐F ☐M		☐poor ☐average ☐good
	☐F ☐M		☐poor ☐average ☐good

Comments: ____________________

____

____

Foster, Adoptive, Grandparent or other Guardians (if none leave blank)

With whom does the child live at this time: ____________________

Are parent's divorced or separated? ____________________

If Yes, who has legal custody? ____________________

Is there any significant information about the parents'/guardians' relationship or treatment toward the child which might be beneficial in counseling? ☐Yes ☐No

If Yes, describe: ____________________

Client's Foster/Adoptive Mother/Guardian (if none leave blank)

Name: ____________________ Age: ______ Occupation: ____________________ ☐FT ☐PT

Where employed: ______________________________ Work Phone: ____________________

Mother's education: ____

Is the child currently living with mother? ☐Yes ☐No

Is there anything notable, unusual or stressful about the child's relationship with the mother? ☐Yes ☐No

If yes, please explain: ____________________

How is the child disciplined by the mother? ______________________________

For what reasons is the child disciplined by the mother? ______________________________

Client's Foster/Adoptive Father/Guardian (if none leave blank)

Name: ____________________ Age: ______ Occupation: ____________________ ☐FT ☐PT

Where employed: ______________________________ Work Phone: ____________________

Father's education: ____

Is the child currently living with Father? ☐Yes ☐No

Is there anything notable, unusual or stressful about the child's relationship with the father? ☐Yes ☐No

If yes, please explain: ____________________

How is the child disciplined by the father? ______________________________

For what reasons is the child disciplined by the father? ______________________________

Client's Foster/Adoptive Siblings and Others Who Live in the Household (if none leave blank)

Others living in the household	Gender	Relationship (cousin, foster child)	Quality of relationship with the client
	☐F ☐M		☐poor ☐average ☐good
	☐F ☐M		☐poor ☐average ☐good
	☐F ☐M		☐poor ☐average ☐good
	☐F ☐M		☐poor ☐average ☐good

Comments: ____

____

____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

- ☐ Allergies
- ☐ Deafness
- ☐ Muscular Dystrophy
- ☐ Anemia
- ☐ Diabetes
- ☐ Nervousness
- ☐ Asthma
- ☐ Glandular problems
- ☐ Perceptual motor disorder
- ☐ Bleeding tendency
- ☐ Heart diseases
- ☐ Mental Retardation
- ☐ Blindness
- ☐ High blood pressure
- ☐ Seizures
- ☐ Cancer
- ☐ Kidney disease
- ☐ Spinal bifida
- ☐ Cerebral Palsy
- ☐ Mental illness
- ☐ Suicide
- ☐ Cleft lips
- ☐ Migraines
- ☐ Cleft palate
- ☐ Multiple sclerosis
- ☐ Other (specify): ______________________

Comments regarding Family Health: ______________________

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurances of miscarriages or stillborns? ☐ Yes ☐ No

If yes, describe: ______________________

Was the pregnancy with child planned? ☐ Yes ☐ No Length of pregnancy: ______________

Mother's age at child's birth: __________ Father's age at child's birth: __________

Child number _____ of _____ total children

How many pounds did the mother gain during the pregnancy? ______________

While pregnant did the mother smoke? ☐ Yes ☐ No If Yes, what amount: ______________

Did the mother use drugs or alcohol? ☐ Yes ☐ No If Yes, what type/amount: ______________

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)
☐ Yes ☐ No

If Yes, describe: ______________________

Length of labor: __________ Induced? ☐ Yes ☐ No Caesarean? ☐ Yes ☐ No

Baby's birth weight ______________ Baby's birth length: ______________

Describe any physical or emotional complications with the delivery:

____

Describe any complications for the mother or the baby after the birth: ______________

____

Length of hospitalization: Mother: ______________ Baby: ______________

Infancy/Toddlerhood

Check all which apply:

☐ Breast fed	☐ Milk allergies	☐ Vomiting	☐ Diarrhea
☐ Bottle fed	☐ Rashes	☐ Colic	☐ Constipation
☐ Not cuddly	☐ Cried often	☐ Rarely cried	☐ Overactive
☐ Resisted solid food	☐ Trouble sleeping	☐ Irritable when awakened	☐ Lethargic

Developmental History:

Please not the age at which the following behaviors took place:

Sat alone:	__________	Dressed self:	__________
Took 1st steps:	__________	Tied shoelaces:	__________
Spoke words:	__________	Rode two-wheeled bike:	__________
Spoke sentences:	__________	Toilet trained:	__________
Weaned:	__________	Dry during day:	__________
Fed self:	__________	Dry during night:	__________

Compared with otheres in the family, child's development was: ☐ slow ☐ average ☐ fast

Age for following developments (fill in where applicable)

Began puberty:	__________	Menstruation:	__________
Voice change:	__________	Convulsions:	__________
Breast development:	__________	Injuries or hospitalization:	__________

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

____

____

Education

Current school: __________ School phone number: __________

Type of school: ☐ Public ☐ Private ☐ Home schooled ☐ Other (specify): __________

Grade: ____ Teacher: __________ School Counselor: __________

In special education? ☐ Yes ☐ No If Yes, describe: __________

In gifted program? ☐ Yes ☐ No If Yes, describe: __________

Has child ever been held back in school? ☐ Yes ☐ No If Yes, describe: __________

Which subjects does the child enjoy in school? __________

Which subjects does the child dislike in school? __________

What grades does the child usually receive in school? ______________________________

Has there been any recent changes in the child's grades? ______________________________

If Yes, describe: ______________________________

Has the child been tested psychologically? ☐Yes ☐No

If Yes, describe: ______________________________

Check the descriptions which specifically relate to your child:

Feelings about School Work:

☐Anxious ☐Passive ☐Enthusiastic ☐Fearful

☐Eager ☐No expression ☐Bored ☐Rebellious

☐Other (describe: ______________________________

Approach to School Work:

☐Organized ☐Industrious ☐Responsible ☐Interested

☐Self-directed ☐No initiative ☐Refuses ☐Does only what is expected

☐Other (describe: ______________________________

Performance in School (Parent's Opinion):

☐Satisfactoy ☐Underachiever ☐Overachiever

Other (describe): ______________________________

Child's Peer Relationships:

☐Spontaneous ☐Follower ☐Leader ☐Difficulty making friends

☐Makes friends easily ☐Long-time friends ☐Shares easily

☐Other (describe): ______________________________

Who handles responsibillity for your child in the following areas?

School: ☐Mother ☐Father ☐Shared ☐Other (specify): ____________________

Health: ☐Mother ☐Father ☐Shared ☐Other (specify): ____________________

Problem behavior: ☐Mother ☐Father ☐Shared ☐Other (specify): ____________________

If the child is involved in a vocational program or works a job, please fill in the following:
What is the child's attitude toward work? ☐Poor ☐Average ☐Good ☐Excellent

Current employer: ____________________ Position: ____________ Hours per week: ______

How have the child's grades in school been affected since working? ☐Lower ☐Same ☐Higher

How many previous jobs or placements has the child had? ______________________________

Usual length of employment: ____________ Usual reason for leaving: ____________________

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

☐ Abortion	☐ Hayfever	☐ Pneumonia
☐ Asthma	☐ Heart trouble	☐ Polio
☐ Pleurisy	☐ Hepatitis	☐ Pregnancy
☐ Bronchitis	☐ Hives	☐ Rheumatic Fever
☐ Cerebral Palsy	☐ Influenza	☐ Scarlet Fever
☐ Chicken Pox	☐ Lead poisoning	☐ Seizures
☐ Congenital problems	☐ Measles	☐ Severe colds
☐ Croup	☐ Meningitis	☐ Severe head injury
☐ Diabetes	☐ Miscarriage	☐ Sexually transmitted disease
☐ Diptheria	☐ Multiple sclerosis	☐ Thyroid disorders
☐ Dizziness	☐ Mumps	☐ Vision problems
☐ Ear aches	☐ Muscular Dystrophy	☐ Wearing glasses
☐ Ear infections	☐ Nose bleeds	☐ Whooping cough
☐ Eczema	☐ Other skin rashes	☐ Other
☐ Encephalitis	☐ Paralysis	☐ Fevers

List any current health concerns:

___

List any recent health or physical changes:

___

Nutrition

Any recent changes in child's weight?: ☐ Yes ☐ No Any recent changes in child's appetite?: ☐ Yes ☐ No

If Yes, describe or list any eating problems/concerns:

___

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination		
Dental examination		
Vision examination		
Hearing examination		

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter medications	Dose	Dates	Purpose	Side effects

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ☐Yes ☐No

If Yes, describe: ______________________________

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment ☐Yes ☐No			
Suicidal thoughts/attempts ☐Yes ☐No			
Drug/alcohol treatment ☐Yes ☐No			
Hospitalizations ☐Yes ☐No			

Has the child/adolescent experienced death? (friends, family pets, other) ☐Yes ☐No

At what age? ____ If Yes, describe the child's/adolescent's reaction: ______________________________

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

☐Yes ☐No

If Yes, describe: ____

Any additional information that you believe would assist in understanding your child/adolescent?

____

____

____

Any additional information that would assist us in understanding current concerns or problems?

____

____

____

What are your goals for the child's therapy?

____

____

____

What family involvement would you like to see in the therapy?

____

____

Do you believe the child is suicidal at this time? ☐Yes ☐No

If Yes, explain: ____

Puckett Counseling Services
Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

If you have any questions about this Notice please contact our Privacy Contact who is: Peggy Smith-Puckett.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *AAMFT Code of Ethics.* It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment – Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment – We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations – We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law – Under the law, we must make disclosures of your PHI to you upon request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

For Treatment – We may use your PHI to provide you with treatment or services. We may disclose medical information about you to therapists, doctors, nurses, or other health care providers to assist in your treatment.

For Payment – We may use and disclose your medical information for payment purposes.

Deceased Persons – To help them carry out their duties, we may share PHI of a person who has died with a coroner, medical examiner, or law enforcement officials.

Without Authorization – Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Child Abuse/Neglect, Elder Abuse and Spouse Abuse – As required by law, suspected cases of elder abuse, domestic violence, child abuse or neglect must be reported to the Department of Protection and Permanency and in some instances, law enforcement authorities. This also includes "dependent adults."
- Required by Court Order – In this case we will do what we can to protect your PHI, while complying with the order of the court.
- Threats to Self or Others – In accordance with Kentucky state law, clients whom we believe to be a threat to themselves or others. In the event that you are determined to be a threat to yourself or others, your therapist will work with you to obtain the appropriate care with disclosing as little information as possible about you or your PHI.

- Mandatory Government Audits/Investigations, such as the social work licensing board.

Verbal Permission – We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization – Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Puckett Counseling Services, PO BOX 682, Tompkinsville, KY 42167.

- **Right of Access to Inspect and Copy** – You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend** – If you feel that the PHI we have about you is incorrect or incomplete; you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures** – You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions** – You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication** – You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice** – You have the right to a copy of this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information or if you think we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information, you may contact the Privacy Office at:

Puckett Counseling Services
Attention: Privacy Officer
2130 Willie Groce Rd.
Glasgow, KY 42141

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Puckett Counseling Services, 2130 Willie Groce Rd., Glasgow, Kentucky 42141 or with the Secretary of Health and Human Services at 200 Independence Avenue, SW, Washington, D.C., 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is April 14, 2003.

Name(s):____

Address:______________________City_______________State________Zip_________

Bill to: Person responsible for payment of Account:______________________________

Address:______________________City_______________State________Zip_________

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay Puckett Counseling Services, here after referred to as PCS, a rate of $__________ per clinical unit (defined as 45-50 minutes for assessment, individual, family and relationship counseling).
A fee of $_________is charged for missed appointments or cancellations with less than 24 hours' notice.
A fee of $_________per hour is charged for services not covered by insurance, such as court appearances, extra report writing time, and any other services not covered by insurance.

Part Two Clients with Insurance (Deductible and Co-payment Agreement)

PCS has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services.

Estimated Insurance Benefits

1) $_______________Deductible amount (paid by insured party)
2) Co-payment ___________% ($________/clinical unit) for first _______visits.
3) Co-payment ___________% ($________/clinical unity) up to _______visits.
4) The policy limit is _____________per year: _______annual_________calendar

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services that are not paid by your insurance policy, all co-payments, and deductible. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for your or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three All Clients

Payments, co-payments, and deductible amount are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Statement for Professional Services.

Person Responsible for Account:____

Date:______________________________

The staff at Puckett Counseling Services (hereafter referred to as PCS) is committed to providing caring and professional mental health care to all our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of PCS is designed to clarify the payment policies as determined by the management of PCS.

The person responsible for payment of account is required to sign the form Payment Contract for Services, which explains the fees and collection policies of PCS. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, PCS will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases insurance companies and third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 1% per month interest rated is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at PCS), this amount will be collected by PCS until the deductible payment is verified to PCS by the insurance company or third-party provider.

All insurance benefits will be assigned to PCS (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The Adult accompanying a minor (or guardian of the minor) is responsible for the payments at the time of services. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan or payment at the time of services.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the payment contract for services.

Payment methods include check or cash.

Questions regarding the financial policies can be answered by Peggy Smith-Puckett.
I (we) have read, understand, and agree with the provisions of the financial policy.

Person responsible for account:________________________________Date____________

Co-responsible party:_______________________________________Date____________

Puckett Counseling Services
Peggy Smith-Puckett, LMFT
220 North Race Street
Glasgow, KY 42141
Phone: (270) 629-6373

Background and Credentials

I am pleased that you have chosen me for assistance. This document is designed to inform you of my background and give you information about the counseling process. I graduated from Western Kentucky University in May, 2003 with a Masters of Education degree in Mental Health Counseling with an emphasis in Marriage and Family Therapy. I am licensed with the Kentucky Board of Licensure of Marriage and Family Therapists as a Marriage and Family Therapist.

Contact Number:

Office: 270-629-6373 (if this number does not answer, you may leave a voice message).
Cell: 270-791-2178 (for emergencies only)

Occasionally, telephone contact is needed between sessions when issues come up or a crisis develops. As a courtesy to my other obligations, both professional and personal, I like to keep phone contact brief. **If there are issues that require more than 5 minutes of phone time, please schedule an appointment.**

Emergency Service

My counseling services are limited to the scheduled sessions we have together. In the event you feel your or your child's mental health requires emergency attention or if you have an emotional crisis, you should follow the crisis action plan which is on the last page of your child's service care plan.

Scheduling, Cancellation and Rescheduling Policy

Scheduling presents a special problem in a therapeutic practice because once a given hour is blocked out; it usually cannot be filled again on short notice. Please note that insurance companies and Impact Plus will not pay for sessions which are missed. The welfare and treatment of your child is very important to me, therefore, I have instituted the following policy regarding no shows and cancellations of appointments: **Three cancellations and/or no shows of appointments without twenty-four hour notice will result in termination of services.** We understand that it is sometimes unavoidable to cancel an appointment due to illness or family emergency; however, it is important that you notify our office as far in advance as possible of any need to cancel an appointment. In the event of three cancellations and/or no shows without twenty-four hour notification, I will contact your child's Service Coordinator to notify them that I will no longer be providing services to your child. Please retain this policy in your records for future reference as it contains contact telephone numbers that you may use to notify my office of the need to cancel an appointment.

Expectations of Therapy

Because I am a family therapist, my main focus will be on the family system which means that I will assess the roles, rules and patterns in the family and how they may help to achieve the goals you are seeking in the process of therapy. Typically, sessions are held weekly. I meet separately with parents for a one to two hour session and your child twice a week for a one hour session. Also, it will be important for everyone in the household to attend any necessary family therapy sessions as needed. Generally sessions with parents take place at the office. You as a family will be expected to identify goals and I, as a therapist will guide you toward achieving those goals. In order to achieve effective results it is necessary for everyone to actively participate in each session. While as a family you may be tempted to talk about one member, my duties as a family therapist will involve refocusing attention to the family relationships and those relationships can be a key to providing the outcome that you desire. In some situations I will be conducting play therapy sessions with your child. In play therapy we provide toys for children to use so they can say with toys what they have difficulty saying with words. When children can

communicate or play out how they feel to someone who understands, they feel better because the feelings have been released. You have probably experienced the same thing when you were bothered or worried about something and then told someone who really cared about you and understood, then you felt better and could handle the problem better. Play therapy is like that for children. They can use the dolls, puppets, paints, or other toys to say what they think or how they feel. Therefore, how children play or what they do in the playroom is very important, just like what you might say in a therapy session is very important. In play therapy, children learn how to express their thoughts and feelings in constructive ways, to control their behavior, to make decisions, and to accept responsibility.

Rights, Risks and Responsibilities

I can assure you that the therapy sessions will be rendered in a professional manner consistent with accepted ethical codes and rules of law. Please note that it is impossible for me to guarantee any specific results regarding the outcome of the therapeutic process. Please note that any changes can have positive or negative effects with regard to any of your personal relationships. If you feel the need to discontinue at any time, for any reason, you may do so by following appropriate steps which include a written letter to our agency which will give me the opportunity to make an appropriate referral as well close your file.

Recourse for Dissatisfaction

Of course I trust that your experience with me will be satisfying and that you find the experience of therapy helpful and delivered in an appropriately professional manner. However, should you have any complaints about the therapy you may speak file a complaint with the Ethics Board of the American Association of Marriage and Family Therapy (202-452-0109).

Consent for Services

Your signature below will indicate that you have read this document, we have discussed it and that you comprehend and voluntarily agree to therapy as it has been described to you. Thank you for providing me with this opportunity to serve you. It is my purpose to provide the best service I am able to give, and I hope we can work together to help you overcome your problems.

Client Name: ______________________________

Social Security Number: ______________________________

Date of Birth: ______________________________

______________________________ ______________
Client Signature Date

______________________________ ______________
Parent/Guardian Signature Date

______________________________ ______________
Parent/Guardian Signature Date

______________________________ ______________
Peggy Smith-Puckett, LMFT Date