FAMILY THERAPY
CENTER OF BETHESDA
Child, Teen, Family & Individual Therapy

8120 Woodmont Ave., Suite 205
Bethesda, MD 20814
PH (240) 600-0968
EM info@familytherapyllc.com

New Client Information: Adolescent

Today's Date: _________

Client Information

Name: ________________________________ **Date of Birth**: _______________ **Age:** ______ **Gender:** _________

Phone Numbers: Home ________________ **Cell**: __________________ **Email**: ______________________________

School:_______________________________________ **Grade:** _____________

Employed: ☐ Yes ☐ No

If yes, where and what hours?: ____

Reason for Seeking Therapy:

Briefly share what brought you to therapy: ____

____

What do you hope to get through therapy?: ____

____

Healthy History:

Have you seen a therapist before? ☐ Yes ☐ No

If yes, please describe (reason for therapy, length etc.): ____

____

If yes, what was most helpful? ____

If yes, what was least helpful? ____

Have you ever received any psychiatric/psychological diagnosis? ☐ Yes ☐ No

If yes, what is the diagnosis, when was it given, and by whom? ____

Are you currently being treated by a doctor for a medical issue? ☐ Yes ☐ No

If yes, please explain: ____

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please indicate medication and dosage: ____

Social Media Use

Social media platforms used: ☐ SnapChat ☐ Facebook ☐ Instagram ☐ Twitter ☐ Other: ________

Do your parents have access to your electronic communications? ☐ Yes ☐ No

Do they have concerns about your use of electronics? If yes, please explain: __________________________________

____

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Substance Use and History

Do you currently use alcohol? ☐ Yes ☐ No

If yes, how much and often do you drink? ____

Do you currently use tobacco? ☐ Yes ☐ No

If yes, how much and how often?: ____

Do you currently use any other drugs? ☐ Yes ☐ No

If yes, what drugs and what frequency?: ____

Have you received any treatment for substance use? ☐ Yes ☐ No

If yes, please describe: ____

Do you have concerns about your substance use? ☐ Yes ☐ No

Family History:

Are your parents married? ☐ Yes ☐ No

If yes, do you think that they have a good relationship? ☐ Yes ☐ No ☐ Unsure

If your parents are not together, whom do you primarily live with? ______________________

How often do you see each parent? Mom __________% Dad ___________%

Family Concerns: (Please check any that apply)

	Arguing		Abuse/neglect
	Physical fights		Feeling distant
	Loss of a family member		Financial stressors
	Alcohol use		Issues regarding remarriage
	Drug use		Inadequate housing
	Infidelity		Lack of trust/honesty
	Birth of a sibling		No time together
	Divorce/separation		Other:

Peer Relationships

How do you consider yourself socially? ☐ Outgoing ☐ Shy ☐ Depends on the situation

Are you happy with the amount of friends you have? ☐ Yes ☐ No

Are you having any problems with your friends? ☐ Yes ☐ No

Do you ever feel social pressures? ☐ Yes ☐ No

Have you ever been bullied? ☐ Yes ☐ No

Are your parents happy with your friends? ☐ Yes ☐ No

Are you involved in any clubs/sports/activities in or out of school? ☐ Yes ☐ No

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School History

Do you like school? ☐ Yes ☐ No

Do you have any attendance problems? ☐ Yes ☐ No

What are your current grades? ________________________

Are you happy with your grades? ☐ Yes ☐ No

Are your parents happy with your grades? ☐ Yes ☐ No

Do you feel like you are doing the best you can at school? ☐ Yes ☐ No

Personal Strengths:

What activities do you enjoy and feel you are successful at? ____

Who are your biggest supports? ____

Use one word that best describes you: ______________________

Individual Concerns:

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Sadness					Difficulty concentrating				
Crying					Difficulty making decisions				
Sleep problems					Low energy				
Problems at home					Excessive worry				
Hyperactivity					Low self worth				
Binging/Purging					Anger issues				
Loneliness					Racing thoughts				
Guilt					Restlessness				
Irritability					Drug use				
Stomach issues					Alcohol use				
Social Anxiety					Easily distracted				
Self harm					Trauma history				
Grief					Obsessive thoughts				
Impulsivity					Panic attacks				
Nightmares					Past suicide attempts				
Hopelessness					Suicidal Ideation				
Mood swings					Phobias				
Anorexia					Weight				
Headaches					Isolation				
Anxiety					Other				

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New Client Information: Parent

Contact Information (parent):

Name: ____

Address: ____

Phone Numbers: Home ________________ Work ________________ Cell __________________

Best number to reach you: ______________________ **Is it OK to leave messages at this number?** ☐ Yes ☐ No

Email: ___________________________________

Current Occupation:______

Demographic Information (parent):

Relationship Status: ☐ Single ☐ Dating ☐ Married ☐ Cohabitating ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed ☐ Other ________________________

Name of your Partner: ____

Email: ____ **Phone Number:** ____________________________

Current Occupation:______

Family Information (please star the primary client):

PLEASE LIST INFORMATION ABOUT ALL CHILDREN					
Name	Gender	Age	School/Grade	Current Living Situation	Participating in Therapy? Y/N

Family Information (please star the primary client):

Briefly describe the problem for which you are seeking therapy for your adolescent: _______________________________

____

What do you hope to result from therapy? ____

____

What is most concerning right now? ____

Would you like to be involved in therapy? ____

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Child's Developmental History:

Were there any complications during pregnancy or delivery? ☐ Yes ☐ No

If yes, please describe: ____

Did your child experience any problems at birth? ☐ Yes ☐ No

If yes, please describe: ____

Did your child experience any developmental delays? ☐ Yes ☐ No

If yes, please describe? ____

____

Any significant medical history: ☐ Yes ☐ No

If yes, please describe: ____

Child's Health History:

Name of Physician: ______________________________ Phone number: ________________________

Is your child currently being treated by a doctor for a medical issue? ☐ Yes ☐ No

If yes, please explain: ____

Has your child seen a therapist before? ☐ Yes ☐ No

If yes, please describe (reason for therapy, length etc.): ____

____

Has your child ever received any psychiatric/psychological diagnosis? ☐ Yes ☐ No

If yes, what is the diagnosis, when was it given, and by whom? ____

Is your child currently taking any medication? ☐ Yes ☐ No

If yes, please indicate medication and dosage: ____

Does your child have any history of hospitalizations for mental health concerns? ☐ Yes ☐ No

If yes, please describe: ____

Family Concerns:

	Arguing		Abuse/neglect
	Physical fights		Feeling distant
	Loss of a family member		Financial stressors
	Alcohol use		Issues regarding remarriage
	Drug use		Inadequate housing
	Infidelity		Lack of trust/honesty
	Birth of a sibling		No time together
	Divorce/separation		Other:

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Substance Use

Do you have any concerns with your child using alcohol and/or drugs? ☐ Yes ☐ No

If yes, please describe: ____

Is there a family history of drug or alcohol use? ☐ Yes ☐ No

If yes, please describe: ____

Electronic Use:

Please indicate your child's social media use: ☐ SnapChat ☐ Facebook ☐ Instagram ☐ Twitter ☐ Other: ________

Do you have any concerns about your child's social media use? ☐ Yes ☐ No

If yes, please describe: ____

Do you have access to your child's social media? ☐ Yes ☐ No

If yes, please describe: ____

About how much time does your child spend on electronics for reasons other than school? _____________________

Strengths:

What activities does your child enjoy? ____

What personal strengths would you say your child has? ____

What supports does your child have? ____

What coping skills does your child have? ____

Individual Concerns you have for your Child:

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Sadness					Difficulty concentrating				
Crying					Difficulty making decisions				
Sleep problems					Low energy				
Problems at home					Excessive worry				
Hyperactivity					Low self worth				
Binging/Purging					Anger issues				
Loneliness					Racing thoughts				
Guilt					Restlessness				
Irritability					Drug use				
Stomach problems					Alcohol use				
Social Anxiety					Easily distracted				

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Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Self harm					Trauma history				
Suicidal					Obsessive thoughts				
Impulsivity					Panic attacks				
Nightmares					Past suicide attempts				
Hopelessness					Grief				
Mood swings					Phobias				
Anorexia					Weight				
Headaches					Isolation				
Anxiety					Other				

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Practice Policies

Our Philosophy of Therapy

As a Marriage and Family Therapists we specialize in working with individuals, couples, families, and groups. We approach therapy from a systemic perspective, meaning that we focus on the dynamics *between* people rather than solely on the individual. Our approach draws from a variety of tools including solution focused and cognitive behavioral techniques, play therapy, experiential exercises, and homework assignments in order to best achieve your personal goals. We view counseling as a vessel to help people find and capitalize on the strengths and skills they already possess as well as to develop and strengthen new skills and tools.

One of the key aspects of successful therapy is building a relationship between therapist and client that is defined by trust, honesty, and openness. Therefore, the beginning of therapy focuses on me getting to know you and working with you to better understand your problem/situation. As the problem becomes clear we can begin to develop goals which we will use to help guide our sessions. Sometimes as we achieve goals you may find that your goals may change or new goals may come to the forefront. Because of this, therapy may last a few sessions but may also last several months or years. Therapy ends when you feel that you have all of the tools to address future problem(s)/situation(s) successfully on your own.

As therapy is a collaborative process, you have the ability at any time to ask us to explain why we are requesting information or suggesting a new approach. We are always open to your questions and feedback. Below is a list of possible risks and benefits associated with therapy.

Possible Benefits

- A better ability to handle relationship, family, and other interpersonal issues.
- Increased self awareness.
- Increased understanding of family and personal goals and values.
- A healthy of emotional wounds inflicted in the past or present.
- Development of tools and healthy coping skills to assist you in managing future problems.
- Greater happiness and overall life satisfaction.
- Resolution of specific concerns brought to therapy.

Possible Risks

- Therapy can sometimes lead to individual decisions that can be disruptive for your self or family.
- Some health insurance companies will not cover the cost of therapy.
- The experiencing of intense and uncomfortable feelings as unpleasant events, relationship patterns, and other concerns are addressed.
- Therapy is not an exact science, so there is no guarantee as to the outcomes. Some people experience no improvement in their situation, and a few may think that things are worse after treatment.

Consent to Release and Exchange Information: At times it will be important for us to contact other professionals who are working with you or your child to ensure you are getting the best, most collaborative care possible. Such professionals may be psychiatrists, doctors, school teachers, or attorneys. We will always ask for written permission before contacting any of these professionals.

Case Consultation: In order to provide the best care possible and in accordance with customary professional behavior, we regularly consult with other experienced therapists regarding client issues. However, we do not reveal any identifying information about our clients during these consultations.

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General Policies

Fees: Payment is expected in full at the time of service. Acceptable forms of payment are cash, check, or credit card. You are required to have a credit card on file in case of missed appointments or late cancelations. If your check is deposited with insufficient funds, you will be charged $35.00 to cover bank fees. If a check is returned by the bank more than two times during treatment, FTCB reserves the right to refuse any future checks and an alternative method of payment will be required. We do not bill insurance companies directly. However, we can provide you with a statement of services for you to submit to your insurance company. Session and other fees are as follows:

- 50 minute therapy hour: $165.00
- 90 minute therapy hour: $290.00
- Fees for additional services, including, but are not limited to, consultation with other professionals, school meetings, preparation of reports or correspondence, any necessary court appearances, and phone conversations lasting over 15 minutes will be charged at $165.00 an hour.
- Travel fees for school based services are $10/session for schools within 15 miles of my office. Any school outside that radius will incur a $15 travel fee/session.

Cancellation Policy: The full fee for the session will be charged in the event of missed appointments or cancellations without 24 hours notice. In some instances, (i.e. true emergencies or circumstances clearly beyond your control), and at our discretion, the charge may be waived.

If you do not contact your therapist and/or your therapist is unable to reach you to schedule future appointments, a letter will be sent informing you that your case is in danger of being closed. If you do not respond, your case will be closed on the date listed in the letter.

Legal Proceedings: It is the mission of FTCB to provide clients with a safe and confidential space in which to work towards their goals. While we am aware that some clients may be involved in or may become involved in various legal proceedings, it is our belief that therapist involvement can be detrimental to the therapeutic relationship and thus a client's ultimate personal and relationship goals. As such, to contain our costs and remain focused on the primary therapeutic goals, it is our longstanding policy and practice not to complete character references or offer court testimony of any kind. To clarify, we will write a case summary of a client's attendance and progress in therapy for him/her to take to court, however, we will not appear voluntarily for a legal proceeding. If we are subpoenaed, despite the policy, the cost of such services is $500/hour per person subpoenaed.

Contact Information: The practice phone number is (240) 600-0968. We will return calls in a timely manner, between 8 a.m. and 6 p.m. Monday-Friday. We will return weekend calls on Monday, unless Monday is a holiday. The practice email is info@familytherapyllc.com.

Email and Phone Policy: To be in complete accordance with HIPPA regulations and to provide you with the greatest level of security for your confidentiality, we use email only for scheduling and clarifying appointment dates and times (or other administrative business). Should you need to speak with your therapist about clinical issues related to therapy, please call and your therapist will be happy to speak with you. Phone conversations lasting over 15 minutes will incur a charge of $165.00 an hour. If family or couple issues arise over the week, please write them down and save them for your next family/couple session. This is optimal to keep the therapeutic relationship balanced, fair, and secret free for participating members and prevents me from acting as a mediator over the phone.

Emergencies: Our aim is to be available for you if an emergency should arise. However, there are times when we may not be available to assist you. If you are in <u>need of immediate attention</u>, do not wait for your therapist to get back to you before taking action. **Please call 911 or the 24-hour hot line at the Montgomery County Crisis Center, (240) 777-4000 or go to the nearest emergency room.**

Termination and Document Retention: The goal of therapeutic work is to give you the strength and tools necessary to handle difficult and challenging situations on your own in the future. When your goals are met and you feel comfortable and confident in your skills you and your therapist will talk about termination. It is important that there be adequate time given before fully terminating to bring closure to the therapeutic relationship and to review and reinforce the skills learned during our time together. In most cases we recommend first decreasing the frequency of sessions for a few weeks and then having at least 1 termination session. You are welcome to return to therapy at any point in the future, even if you case has been closed.

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Documents related to cases are kept for seven years or, if the client is a minor, until a minor child is seven years past the age of 18, as required by law. At that time, all records are destroyed by shredding to protect your confidentiality.

I understand that Family Therapy Center of Bethesda, LLC therapist, _________________, will provide professional services to:
Client name(s): ____

My signature below affirms my informed and voluntary consent to enter therapy (and/or have my child/ren enter therapy). I affirm that prior to becoming a client of Family Therapy Center of Bethesda, LLC I was given sufficient information to understand the nature of therapy, including the possible risks and benefits, and also the nature of confidentiality. I understand FTCB office policies and procedures and cancellation policy. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that I can ask questions and raise concerns about the treatment any time during therapy.

____________________________________	____________________________________	___________
Name (Please Print)	Signature	Date
____________________________________	____________________________________	___________
Name (Please Print)	Signature	Date
____________________________________	____________________________________	___________
Name (Please Print)	Signature	Date
____________________________________	____________________________________	___________
Name (Please Print)	Signature	Date

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Confidentiality

1. As your therapist I strive to provide you with a safe place in which you can openly explore very personal and difficult issues. I am committed to guarding your right to privacy, within the limits of the law. There are issues surrounding confidentiality of which you should be aware.
2. There are certain situations in which a **therapist is required by law to disclose information** obtained during therapy. Disclosure is required by law in the following circumstances:
   a. A reasonable suspicion of abuse/neglect of a child or vulnerable adult. A report will be made to appropriate protective agencies.
   b. When you threaten grave bodily harm to others. As a therapist, I have a duty to warn those you have threatened.
   c. When you are suicidal or threaten significant bodily harm to yourself. I have a duty to obtain help from others such as family members or other professionals to do what is necessary to keep you safe.
   d. When a court of law issues a legitimate court order (signed by a judge).
   e. When you are in a probation or parole period or other legal situation that would require disclosure.
3. Except in the above circumstances, I will release information about you only if you provide a written request. Releases of information for families/couples in therapy required the written permission of every member of the family/couple in treatment able to execute a waiver.
4. We live in a small community. As a result, there may be times that I may run into you in the community. My number one priority is to maintain your confidentiality. Due to this, I will not initiate a conversation with you or acknowledge that I know you. It is your decision whether you want to acknowledge and/or approach me. Please know that if you choose not to acknowledge me, I will not take any offense.
5. Clients under the age of 18 are considered minors and therefore all therapy contracts must be signed by their custodial parent(s) or legal guardian(s). Therefore, custodial parent(s) and/or legal guardian(s) have a right to information discussed during sessions, particularly information pertaining to the minor's safety. However, parent(s) and guardian(s) should be aware that part of the therapeutic process that allows individuals to be open and honest is developing trust and maintaining confidentiality. If parents frequently obtain and use information shared in their child's session with the therapist, the child may not feel safe continuing with therapy in an open and honest way. Therefore, exercising this right to information with discretion is advised. Please know, however, that any time I feel that there is information that is pertinent for a parent/guardian to know, I will share it openly and immediately.
6. There are special confidentiality concerns for families and couples in treatment.
   a. I view the family or couple as a "treatment unit."
   b. There are times when I may see the whole treatment unit and times when I may see parts and/or individuals. Please be aware that I will not reveal any individual's confidences to others in the treatment unit without that person's permission.
   c. It is, however, important for you to be aware that secrets shared individually are generally not healthy for you or for your family and may be causing some of the presenting problems in treatment. Therefore, if an individual member or subset of the treatment unit discloses a secret that has significant bearing on the other members of the unit, I will encourage the person(s) to share this information with the other member(s). I will work with and support the individual(s) in finding healthy and safe ways to disclose this information to the other participating member(s).
   d. Should someone reveal a secret to me that puts me in a position that compromises my honest relationship with the others in the treatment unit and refuses to disclose this secret to other participating member(s), treatment will be terminated.

I affirm that I have read about the nature of confidentiality in therapy set forth above. I have had an opportunity to ask questions and have had my questions answered satisfactorily.

____________________________	____________________	__________
Name (Please Print)	Signature	Date
____________________________	____________________	__________
Name (Please Print)	Signature	Date
____________________________	____________________	__________
Name (Please Print)	Signature	Date

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Child/Teen Confidentiality

Please note that adolescent therapy brings special confidentiality policies for you to be aware of. Your child has the right to private, confidential communication with any doctor, therapist, and treatment team providing their care. This means that some of the issues that will be discussed during therapy will stay between your child and their therapist and will not be disclosed to anyone, including you, unless your child has given permission. This is done to ensure that your child feels that they have a safe space to be open and honest during therapy. Having this space will significantly help in their treatment and progress towards desired change.

While we recognize and respect their need to privacy, we also recognize that you may want some insight into what is going on during the therapy process so that you can do your job as their parent. We want you to know that it is always our goal to encourage your child to be open and honest with you and will help support your child to share important issues with you. As mentioned above, there are limits to confidentiality and disclosure is required by law in the following circumstances:

a. A reasonable suspicion of abuse/neglect of a child or vulnerable adult. A report will be made to appropriate protective agencies.
b. When you threaten grave bodily harm to others. As a therapist, I have a duty to warn those you have threatened.
c. When you are suicidal or threaten significant bodily harm to yourself. I have a duty to obtain help from others such as family members or other professionals to do what is necessary to keep you safe.
d. When a court of law issues a legitimate court order (signed by a judge).
e. When you are in a probation or parole period or other legal situation that would require disclosure.

We also want you to know that we recognize how challenging it is to be a parent and that your hope is to be connected with your child and know what is going on in their life. We want you to know that we want to be your partner in supporting your child’s physical and emotional wellbeing, and even when we can’t directly discuss certain details about your child with you, we will always be there to support you. Please know that we are available to answer questions you may have and can provide a general overview of your child’s therapy and progress. We also are there to help support you in developing strategies to implement at home that will foster not only your child’s development but your relationship with your child as well.

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Electronic Communication Policy

Email and texting often offers an easy and convenient way for therapists and clients to communicate, but they can also introduce unique confidentiality challenges. At Family Therapy Center of Bethesda, LLC (FTCB), we are dedicated to protecting your privacy. Below are some guidelines for contacting your FTCB therapist using email or text.

- We prefer only to use email to arrange or modify appointments. Please know that if you choose to email content related to your therapy sessions, the information is not completely secure or confidential. If you wish to use email for more detailed communication, please know that your therapist will remind you of this policy in writing and reserves the right to not respond via email or text but instead contact you by phone to discuss.
- For emergencies, please go to an emergency room. Do not use email or text for emergencies.
- Email and texting is not a substitute for seeing your therapist. If you think you might need to be seen, please call and schedule an appointment.
- Emails and texts should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- Email and texting is not confidential. Be aware that if you send emails from work or texts from a work phone, your employer has a legal right to read the content.
- Emails and texts are part of your legal record; a copy will be put in your file.
- Either you or your therapist can revoke permission to use email or texting at any time.
- Please note that like phone calls, emails and texts will be responded to within normal business hours. Any emails or texts sent after hours or over the weekend will be responded to on the next business day.

Please initial below:

______ I have read the above information and understand the limitations of electronic communication. I understand that my therapist at FTCB may not be able to communicate with me electronically about my specific issue if there are concerns regarding confidentiality. I also understand that if I choose to communicate personal therapy-related content via email or text, I alone assume all potential risks regarding confidentiality.

Please mark your choice(s) regarding how we handle electronic communications with you:

______ It is permissible for my therapist at FTCB to contact me via email regarding scheduling.
______ It is permissible for my therapist at FTCB to contact me via text regarding scheduling.
______ It is not permissible for my therapist at FTCB to contact me via email.
______ It is not permissible for my therapist at FTCB to contact me via text.

_____________________________________ ________________
Client Signature Date

_____________________________________ ________________
Client Signature Date

_____________________________________ ________________
Therapist Signature Date

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Electronic Payment Authorization

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Cash, Check, Visa, MasterCard and Discover.

Payment Source: ☐ **Credit Card** ☐ **Check** ☐ **Cash**

Client Information:

Client Name: ______________________________________ Date of Birth: __________________

Cardholder Information (if different from above):

If using credit card, please indicate the name and address associated with the credit or debit card you wish to use.

Name: ____

Address: ________________________ City__________________ State: _______ Zip: ________

Email: ____

I authorize any service fees to be deducted from the credit or debit card ending in _____________ (provide the last four digits of the card).

______________________________________ ____________________
Cardholder Signature Date

Credit/Debit Card Information:

If using credit card, please provide your payment information below. The debit or credit card information you provide on this form will be shredded once your first payment has been made.

Card Type (circle one): Visa MasterCard Discover

Card Number: ____

Expiration Date: _____________ CVV: ________________________

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Newsletter

Want to get great resources for you, your kids, and your family right to your inbox each month?!?
Family Therapy Center of Bethesda now offers a free monthly newsletter! Sign up today to receive the following great resources each month:

- Book recommendations
- Community events
- Blog
- Parenting tips
- Therapist Q&A

Please initial below to indicate your preference. Feel free to cancel your subscription anytime.

______ Sign me up!
______ No thanks, I'll pass

_____________________________________ ________________
Client Signature Date

_____________________________________ ________________
Client Signature Date

_____________________________________ ________________
Therapist Signature Date