Connie Hornyak

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Child Intake Form

Child's Full Name: (Last) (First) (Middle)

Address Gender: F M

Home Phone Number Date of birth

Whom may we thank for referring you?

Name

Address

Phone Numbers Email address

Parent #1	Parent #2
Name	Name
Address	Address
Home phone Mobile phone	Home phone Mobile phone
Fax number	Fax number
Email Address	Email Address
Place of Employment and Address	Place of Employment and Address
Occupation	Occupation

Parent #1	Parent #2
Date of birth	Date of birth
Marital status	Marital status
Date of marriage	Date of marriage
Date of separation (if applicable)	Date of separation (if applicable)
Date of divorce(if applicable)	Date of divorce(if applicable)
Date widowed (if applicable)	Date widowed (if applicable)

Does your family have a religious affiliation? _____ If so please describe: _____

_____

Who has legal custody of child? _____

With whom is child currently living?

_____ Biological parents _____ Biological mother and stepfather

_____ Adoptive parents _____ Biological father and stepmother

_____ Foster parents _____ Relatives (names: _____)

_____ Biological mother only _____ Institution (name: _____)

_____ Biological father only _____ Other: _____)

If child is adopted, what factors led to parent(s) decision to adopt? _____

_____

_____

_____

_____

Sibling information:

Name	Date of Birth	RELATIONSHIP (full/half sib., foster, biological, adopted)	CURRENTLY LIVING (in home, away at school, with another family, etc.)

Information about others living in the home:

Name	Age	Gender	Relationship to Child

How would you describe your child's physical appearance? (e.g. height, weight, eye and hair color, distinguishing characteristics, manner of dress):

With whom has child lived in the past?

(Please record as much information as you can. Placements should include any hospitalizations and interim moves, no matter how brief. Use additional pages if needed).

DATES	TYPE OF PLACEMENT*	NAMES OF CAREGIVERS	REASON FOR MOVE

*TYPE OF PLACEMENT: Birthparent(s), birth relative(s), foster parent(s), adoptive parent(s), step parent(s), group home, institution, residential treatment center, other.

PLEASE DESCRIBE CHILD'S BIRTH AND DEVELOPMENTAL HISTORY, IF KNOWN:

Age of birthmother at time of child's birth _____

Birthmother's total number of pregnancies _____

(this child was pregnancy # _____)

Miscarriages _____

Abortions _____

Problems during pregnancy with this child:

_____ None

_____ Unusual swelling

_____ Unusual weight gain (if yes, how much?_____)

_____ Unusual weight loss (if yes, how much? _____)

_____ High blood pressure

_____ Infection

Problems during pregnancy with this child: (continue)

Bleeding _____

Unusual vomiting_____

Medicines taken during pregnancy (please list names and reasons for taking): _____

_____

_____

Disease or exposure to contagious disease (please explain):

_____

_____

Persistent emotional stress, depression, or anxiety (please explain):

_____

_____

_____

Smoking during pregnancy _____

Alcohol use _____

Use of street drugs (please list): _____

Other: _____

Did birth mother have prenatal care? _____ When? _____

Was pregnancy full-term? _____ Premature? _____

Was mother depressed during the pregnancy? _____

Was mother ambivalent about the pregnancy? _____ Why? _____

_____

Was father supportive during the pregnancy? _____ If not, why? _____

_____

Was mother on any type of medication during pregnancy? (If so, please list _____ medication and reason for use): _____

_____

Delivery occurred during the ____ th month of pregnancy

How long was labor? _____ Natural? _____ Induced? _____

Were there any complications during labor? _____ If yes, please explain: _____

_____

Was delivery at home? _____ In a hospital? _____Other? _____

Was delivery attended by a physician?_____ Midwife? _____

Other? _____ Was delivery normal?_____ If not, were forceps used? _____

Was birth breech? _____ Was cord wrapped around infant's neck? _____
Was a Caesarean section performed? _____
Was this a multiple birth? _____ If so, how many? _____
What was child's birth weight? _____ Length? _____
At birth, was the infant jaundiced? _____
Did s/he experience anoxia (oxygen deficiency)? _____
Was an incubator necessary for an extended period of time? _____ If so, how long? _____
Were caregivers allowed to take infant out of incubator and hold him/her? _____
Was the infant diagnosed with in-utero alcohol exposure? _____
Was the infant diagnosed with in-utero drug exposure? _____
If yes, to which drugs? _____
Did examination at birth reveal any physical disorders? If so, please explain: _____
_____

Mother's health after childbirth was(circle one) good poor. If poor, please explain:
_____

On what day in the hospital did mother first see the baby?
Did mother hold the baby? _____ If so, on what day? _____
How long were mother and baby in the hospital before coming home? _____
Were there problems with child in the hospital before coming home? _____

_____ No problems
_____ Infection (what type?) _____
_____ Convulsion
_____ Pain (please describe) _____
_____ Other (please explain) _____

How did mother respond to the child's fussiness?

_____
_____
_____
_____
_____
_____

During infancy, were any of the following problems present?

_____ Constant whining
_____ Rageful crying
_____ Extremely sensitive to touch
_____ Extremely resistant to cuddling
_____ Limp when held
_____ Stiff when held
_____ Child arched back and resisted being held
_____ Poor sucking response
_____ Poor eye contact, lack of tracking with eyes
_____ No reciprocal smile response
_____ Indifference to others
_____ Choked easily
_____ Vomited or spit up frequently
_____ Child was unusually nervous or jittery
_____ Child had colic (until age: _____)
_____ Difficulty swallowing
_____ Difficulty chewing
_____ Held breath for long periods of time
_____ Had allergic reactions to:_____
_____ Other:

At what age did each of the following occur?

_____ Smiled
_____ Sat without support
_____ Walked alone
_____ Spoke first word
_____ Used two or three word sentences
_____ Was completely weaned
_____ Started toilet learning
_____ Completed toilet learning (bladder)
_____ Completed toilet learning (bowel)
_____ Relapses of bladder or bowel control

Was the above information from your baby book, diary, reports, or memory? _____

If child was abused, neglected, or institutionalized, please describe the child's experiences (if known):

PHYSICAL DEVELOPMENT:

Please describe child's large muscle development (e.g. walking, hopping, skipping, riding a bicycle).

Please describe child's small muscle development (e.g. using a pencil, doing puzzles).

Which hand does child prefer to use? _____ Is preference consistent? _____
Is child's speech normal? _____ If not, please describe. _____
Has child ever had speech therapy? _____
Is child's hearing normal? _____ If not, please describe. _____

Name of child's physician _____ Physician's address _____

Physician's phone _____ Date of most recent physical examination: _____

What is child's present health condition? _____

Does child have any health problems? If so, please describe: _____

MEDICAL INFORMATION (must be completed):

Please list child's medications below, beginning with current medication, and working backward:

Dates	Name of Medication	Amount (ex -10 mg.)	Taken when:	Prescribed by:	Child's reaction:

EDUCATION: Please list all schools attended, beginning with the current school:

Dates and grades Attended	Name of school	Address and Telephone no.	Behavior problems, if any

Does your child enjoy being in school? _____ Specific likes and dislikes:(if known):

_____

_____

Has your child been diagnosed with learning disabilities? If so, please indicate:

_____

_____

SOCIAL ADJUSTMENTS:

How would you describe your child's interpersonal relationships?

With mother _____

With father _____

With brother(s) _____

With sister(s) _____

With peers _____

With teachers _____

PRESENTING PROBLEMS:

Please describe in detail the issues that have brought you to counseling:

_____

_____

_____

_____

_____

_____

Discuss your hopes for bringing your child and family to counseling.

Please list your child's positive qualities:

What questions would you like to have answered about your child?

Professional Counseling or Therapy	Dates	Therapist's name, address, phone	Results
This child:			
Mother:			
Father:			
Brothers:			
Sisters:			
Family:			

Information in this intake form provided by. _____

Relationship to child. _____

Date provided. _____

FAMILY HISTORY (to be filled out by each parent)

Parent 1 _____

Family of Origin

Describe your mother and father (positive and negative qualities):

_____

_____

_____

_____

_____

How did your parents show affection to each other and their children?

_____

_____

_____

_____

_____

How did your parents handle disagreements and conflicts? What were their main methods of discipline?

_____

_____

_____

_____

_____

How many siblings do you have? _____

What role did each sibling play in the family?

Does your family have a history of alcohol or drug abuse? If so, please describe, including how the issue was dealt with:

Was there mental or emotional illness in your family? If so, please describe, including how the issue was dealt with:

On a scale of one to ten, with ten being the most stressful, how stressful was the home in which you grew up? Why do you think this was so?

Medical History

List any current/past illnesses/injuries that have impacted you or your family:

Marital History

Describe your current marriage, including both positive and negative qualities (e.g., intimacy, communication, problem-solving, togetherness).

Briefly list and describe any previous marriages.

Current Family

List your other children and give a brief description of each child.

What are your main methods of discipline and how effective have they been?

What concerns do you have with any other member of the family?

How large of a role, if any, does religion play in your family?

Describe your family's positive attributes, strengths and support systems:

FAMILY HISTORY (to be filled out by each parent)

Parent 2 _____

Family of Origin

Describe your mother and father (positive and negative qualities):

_____

_____

_____

_____

_____

How did your parents show affection to each other and their children?

_____

_____

_____

_____

_____

How did your parents handle disagreements and conflicts? What were their main methods of discipline?

_____

_____

_____

_____

_____

How many siblings do you have? _____

What role did each sibling play in the family?

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List your other children and give a brief description of each child:

What are your main methods of discipline and how effective have they been?

What concerns do you have with any other member of the family?

How large of a role, if any, does religion play in your family?

Describe your family's positive attributes, strengths and support systems:

Place a check next to each behavior your child currently exhibits or has exhibited.

1. Is excessively distressed when separated from family ☐
2. Exhibits excessive anxiety or worry ☐
3. Has difficulty arising in the AM ☐
4. Is hyperactive and excitable in the PM ☐
5. Sleeps fitfully or has difficulty getting to sleep ☐
6. Has night terrors or frequently wakes in the middle of the night ☐
7. Is unable to concentrate at school ☐
8. Has poor handwriting ☐
9. Has difficulty organizing tasks ☐
10. Has difficulty making transitions ☐
11. Complains of being bored ☐
12. Has many ideas at once ☐
13. Is very intuitive or very creative ☐
14. Is easily distracted by extraneous stimuli ☐
15. Has periods of excessive, rapid speech ☐
16. Is willful and refuses to be subordinated ☐
17. Displays periods of extreme hyperactivity ☐
18. Displays abrupt, rapid mood swings ☐
19. Has irritable mood states ☐

20. Has elated or silly, giddy mood states ☐

21. Has exaggerated ideas about self or abilities ☐

22. Exhibits inappropriate sexual behavior ☐

23. Feels easily criticized or rejected ☐

24. Has decreased initiative ☐

25. Has periods of low energy or withdraws or isolates self ☐

26. Has periods of self-doubt and poor self-esteem ☐

27. Is intolerant of delays ☐

28. Relentlessly pursues own needs ☐

29. Argues with adults or bosses others ☐

30. Defies or refuses to comply with rules ☐

31. Blames others for his or her mistakes ☐

32. Is easily angered when people set limits ☐

33. Lies to avoid consequences of actions ☐

34. Has protracted, explosive temper tantrums or rages ☐

35. Has destroyed property intentionally ☐

36. Curses viciously in anger ☐

37. Makes moderate threats against others or self ☐

38. Has made clear threats of suicide ☐

39. Is fascinated with blood and gore ☐

40. Has seen or heard hallucinations ☐

Treatment contract

I(we) _____
voluntarily enter into this agreement with Connie Hornyak, LCSW to provide treatment services for _____
age_____ , date of birth: _____(hereinafter referred to as "Child"). I (we) agree to participate in the therapeutic process as well.

I am (we are): _____ Adoptive parent(s)
_____ Biological parent(s)
_____ Legal guardian(s)
_____ Legal guardian(s)

I am (we are) aware that there are certain risks inherent in treating children with severe emotional problems. Potential effects, though rare, could include: a worsening of symptoms, increasing difficulty in relationships between parents or between parents and child, surfacing of repressed memories in both children and parents, presentation of false memories, false allegations of abuse, suicidal ideation or psychotic episodes. These risks are greater if child and family do not complete the program, or if they do not follow the treatment plan developed by developed by Connie Hornyak, LCSW.

I (we) agree that the proper jurisdiction and venue for any action shall be in Orange County, California, and shall be construed in accordance with California Law.

Our codes of ethics and various laws of the state of California insure that the conversations you will be having with your therapist will be held in the strictest confidence. Matters you share in your counseling session will not be disclosed without your permission in writing. There are, however, certain exceptions to this rule that you need to know, in case any of them concern you in the future. Legal and ethical requirements specify certain conditions in which it may be necessary for your therapist to discuss information about your treatment with other professionals,
significant others in your life, authorities or institutions. If you have any questions about these limitations, please ask about them before we begin treatment or at any time during our treatment. Such situations include, but are not limited to, the following:

1. If your therapist believes there is a danger that you may harm yourself or others, or that you are incapable of caring for yourself.
2. If your therapist becomes aware of your involvement in the abuse of children, elderly or disabled persons.
3. If your therapist is ordered by a Court to release records, including E mail and text message communication. This sometimes happens when clients are plaintiffs or defendants in lawsuits and psychological records are subpoenaed as part of that process. Typically, this is because you disclose having been in therapy.
4. If your insurance company requests records in order to verify the services received and determine compensation.

Treatment contract (cont.)

Occasionally, in order to provide you with the best possible services, your therapist may consult with a senior advanced therapist if it is believed that additional expertise would be helpful. This is always done in a way so that certain details are camouflaged, and your full identity is never revealed. Connie Hornyak, LCSW also makes it a habit to consult with clinicians outside of Orange County.

This Treatment Contract is effective beginning _____
and will remain in effect until either party wishes to terminate by giving notice in writing. Parent(s) guardian(s) or placing agency do not need to give a reason for termination, but agree to bring the child in for a termination session with the child's therapist. This ensures closure in the treatment relationship between the child and his/her therapist.

This Treatment Contract is intended as the complete integration of all understandings between the parties, and shall be binding upon the parties hereto and their respective heirs, personal representatives and assigns.

We have carefully read and fully understand this Treatment Contract and will abide by its terms.

EXECUTED this_____day of _____ , 20___.

PARENT(S), GUARDIAN(S), OR PLACEMENT AGENCY

By _____

_____

Street Address

_____

City, State, and Zip

_____

Phone(s) _____

_____

Connie Hornyak, LCSW

1000 Quail Suite 242
Newport Beach 92660
Phone: (714)-785-3407
FAX: (714) 202-3715
email: connie@icfd.net

Connie Hornyak

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connie@icfd.net

Fee agreement

I (We), _____ agree to pay for the

treatment of _____ by Connie Hornyak, LCSW.

I (We) agree to be responsible for payment to Connie Hornyak, LCSW, for all services rendered. I (We) understand that Connie Hornyak, LCSW, will assist me (us) in collecting insurance reimbursement, but that I am (we are) ultimately responsible for obtaining this reimbursement. Costs of sessions are as follows:

PSYCHOTHERAPY FEES

Individual or Family Psychotherapy, 100 minutes	$350.00
Individual or Family Psychotherapy, 75 minutes	$265.00
Individual or Family Psychotherapy, 50 minutes	$175.00
Individual or Family Psychotherapy, 25 minutes	$ 90.00
Individual or Family Psychotherapy, 15 minutes	$ 45.00
Three-session assessment (75 min. each session)	$800.00
Three-session assessment with report	$1065.00

Court reports, time spent in the Courtroom or waiting outside, preparation, being on call, and travel per hour $400.00
There is a four-hour minimum charge for Court related matters, payable one week in advance, by cashier's check or credit card only.

Check or cash payments receive a $5 discount per 50 minutes of services.

PAYMENTS & INSURANCE REIMBURSEMENT:

Clients are expected to pay their fee at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, and travel time will be charged at the same rate. Please notify your therapist if any problem arises during the course of therapy regarding your ability make timely payments. Health insurance is a contract between you and your insurance company. Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. You will be provided with a "superbill" that you can submit to your insurance company for reimbursement.

CANCELLATION:

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for re-scheduling or canceling an appointment. The full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I have read the above Fee Agreement. I understand and agree to comply with it.

Signature	Name (print)	Date	Relationship to client
Signature	Name (print)	Date	Relationship to client

Therapist's signature Date

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