Olympia Therapy PLLC
1534 Bishop Rd SW
Tumwater, WA 98512
360.357.2370 office
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info@olympiatherapy.com
www.olympiatherapy.com

Child's Name: _____ Today's Date: _____
Child's Age: _____ Date of Birth: _____Gender: _____
Grade in school: _____ School: _____

Parents are (choose one): ☐Married ☐Separated ☐Divorced ☐Widowed ☐Living Together
If separated or divorced, how old was the client when the separation occurred? _____
The client is living with: ☐Both parents
☐One Parent (please specify): _____
☐Other (please specify):_____
Who has primary custody? _____
Is there a parenting plan? ☐YES ☐NO
Please describe the current visitation schedule (if any) and type of communication with the child's other parent(s):
_____
_____
Who, and by what method is best for making contact regarding the client?
_____

Contact Information:
Parent/Caregiver Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ May we leave a message? ☐YES ☐NO
Cell Phone: _____ May we leave a message? ☐YES ☐NO
Work Phone: _____ May we leave a message? ☐YES ☐NO
Email: _____ May we email you? ☐YES ☐NO
Does client live with this parent? ☐YES ☐NO

Parent/Caregiver Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ May we leave a message? ☐YES ☐NO
Cell Phone: _____ May we leave a message? ☐YES ☐NO
Work Phone: _____ May we leave a message? ☐YES ☐NO
Email: _____ May we email you? ☐YES ☐NO
Does client live with this parent? ☐YES ☐NO

Please list the client's siblings (including adopted and/or step-siblings):

First Name	Biological, adopted, or step	Current age	Gender	Lives with client?

Please answer the following questions:

What brings child into counseling?_____

What do you hope to get out of counseling?_____

Give 3 adjectives to describe child:_____

Likes/skills:_____

Dislikes/challenges:_____

Recreation/Hobbies:_____

Social: □Many Friends □Few Friends □Mostly Acquaintances □Introvert □Extrovert _____

Legal Challenges: □YES □NO If yes, explain: _____

_____

Health Information:

Primary care physician: _____ Phone number: _____

Rate the child' physical health: ☐Excellent ☐Good ☐Average □Declining

Has child, or a family member, ever been diagnosed with a mental health disorder?□YES □NO

If yes, please specify:_____

_____

Has child ever seen a mental health therapist is the past?□YES □NO If yes, when?_____

Any recent or history of hospitalization (mental, surgeries, truama): □YES □NO If yes, when and for what?_____

_____

Is child currently or had history of thoughts about harming self or others? □YES □NO If yes, please explain:

_____

Current or history of: Domestic Violence? □YES □NO --- Verbal Abuse? □YES □NO --- Physical Abuse? □YES □NO

If yes, please explain? _____

Currently taking medications? ☐YES ☐NO If yes, please specify: _____

Is there a history of exposure to drugs and/or alcohol? ☐YES ☐NOIf yes, explain: _____

Family History of Drug or Alcohol Use?_____

_____

Is there any other information I should know about the child?

_____

_____

_____

_____

_____

_____

How did you hear about us? ☐Relative ☐Friend ☐School ☐Doctor/clinic ☐Internet ☐ Other _____

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: ..... Date:.....

Name of Child:.....

	Please mark under the heading that best fits your child			For Office Use		
	NEVER	SOMETIMES	OFTEN	I	A	E
1. Fidgety, unable to sit still						
2. Feels sad, unhappy						
3. Daydreams too much						
4. Refuses to share						
5. Does not understand other people's feelings						
6. Feels hopeless						
7. Has trouble concentrating						
8. Fights with other children						
9. Is down on him or herself						
10. Blames others for his or her troubles						
11. Seems to be having less fun						
12. Does not listen to rules						
13. Acts as if driven by a motor						
14. Teases others						
15. Worries a lot						
16. Takes things that do not belong to him or her						
17. Distracted easily						
(scoring totals)						

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:

PSC-17 - I ≥ 5

PSC-17 - A ≥ 7

PSC-17 - E ≥7

Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

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Appointment Reminders

As a courtesy service, Olympia Therapy offers appointment reminders. Although we offer this service, it is the patient's responsibility to know when appointments are scheduled. Missed appointments will incur a NO SHOW fee of $50. LAST MINUTE CANCELLATIONS under 24 hours will incur a fee of $50.

Notice of confidentiality:
These communications may contain information that is protected by Federal Confidentiality laws (42CFR, Part 2). When you choose to communicate Patient Identifiable Information by responding to these communication methods, you are consenting to the associated communication risks. Please note communication methods are not secure, and I cannot guarantee that information transmitted will remain confidential.

Patient's Name: _____

Please select ONE (1) of the following options:

☐ Phone Call Reminders: (10 Digit Phone Number): _____

☐ Text Reminders: (10 Digit Phone Number): _____
Mobile Carrier (Text message rates apply)

You may also select an email reminder in addition to a phone or text reminders:

☐ Email Reminders: (Email Address): _____

By signing this, you understand and agree to the above statement:

_____
Print

_____ _____
Sign Date

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Financial Responsibility Information:

Date: _____

Name of Patient:_____ DOB Patient_____/_____/_____ Male/Female

Address: _____ City _____State_____ Zip code _____

Home Phone: _____ Mobile Phone: _____

****Email:**_____

Primary Insurance Information:

Subscriber Name:_____ Subscriber Date of Birth: _____/_____/____ Male/Female

Full Address: _____ City _____State_____ Zip code _____

Home Phone: _____ Cell: _____ Email:_____

Patient Relationship to Subscriber: _____

Name of Insurance Company: _____

Subscriber's ID#_____ Group # _____

Co-pay amount: _____ Customer Service Phone # _____

Secondary Insurance Information:

Subscriber Name:_____ Subscriber Date of Birth: _____/_____/____ Male/Female

Full Address: _____ City _____State_____ Zip code _____

Home Phone: _____ Cell: _____ Email:_____

Patient Relationship to Subscriber: _____

Name of Insurance Company: _____

Subscriber's ID#_____ Group # _____

Co-pay amount: _____ Customer Service Phone # _____

Financially Responsible Party Signature: X_____

Fees for Senior Clinicians (and Professional Associates) at Olympia Therapy apply as follows: Initial session (1 hr) is billed at $200; Subsequent sessions (50 mins) are billed at $160 (PA $50) for individuals and $180 (PA $100) for couples or families. Standard fees apply for 3rd party reports at $70 per ½ hour. **Payment** is due the same day of service and may be paid by check, cash, card, or online using the payment option on our website. **Cancellation Policy:** If you are unable to keep an appointment, please let us know at least 24 hours in advance of your appointment. **Managed Care:** Payments made in part of in full by a managed care organization (MCO) require compliance to the regulations of your plan. As your policy is a contract between you and your carrier, it is your responsibility to check with your insurance provider to confirm terms and limitations of coverage. **If your insurance fails to pay, for whatever reason, you are responsible for the full-billed amount.**

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Credit Card Payment Authorization Form

Credit Card Information
Card Type: □ MasterCard □VISA □ Discover □ AMEX □ Other: _____
Cardholder Name (as shown on card): _____
Card Number: _____ - _____ - _____ - _____
Expiration Date (mm/yy): _____ - _____
CVC Code (3 digits - back of card): _____
Cardholder ZIP Code (from credit card billing address): _____

*Name of minor/family member patient (If Applicable): _____

I, _____, authorize Olympia Therapy PLLC to charge my credit card, listed above, for agreed upon purchases. I understand that my information will be saved on file for future transactions on my account.

□ Please check the box if you would like to enable Autopay on your account.
AutoPay will process the payment on the 1st day of the month for any outstanding balances.

_____ _____
Signature Date

_____
Printed Name

**Last Minute Cancellations (LMC) and No Shows (NS) will be charged a fee of $50 by the end of the week if Administration is not provided a reason for the cancelation within 48 hours.