Robin Kahler, L.M.S.W., A.C.S.W.
1817 W. Stadium, Suite I, Ann Arbor, MI 48103
(734) 645-0580

Parental History Form on a Child / Adolescent

Your Child's Name: ____ Age: ___________

Your Name: ______________________________ Relationship to client: _____________

What are you wanting from therapy?____
____
____

What is your child experiencing (please circle)?

Hopelessness
Crying spells
Loneliness
Emptiness
Worthlessness
Difficulty concentrating
Depressed mood
Suicidal thoughts
Loss of appetite
Sleeping ________hrs
Decreased activity
Decreased self care
Loss of weight _____lb
Weight gain _______lb
Guilt / Shame

Anxiety
Panic attacks
Shortness of breath
Fear of dying
Phobias
Racing thoughts
Job Stress
Nightmares
Flashbacks
Relationship problems
Sexual problems
Screaming/yelling
Hitting
Food Binging
Food purging

Mood Swings
Lots of energy
Confusion
Spending problems
Gambling problems
Worry about what others think
Hearing Voices
Seeing things others don't
Feeling controlled
Unusual thoughts
Homicidal thoughts
Increased alcohol use
Increased drug use
Blackouts
Withdrawal symptoms

Frequent headaches
Frequent stomach aches
Difficulty making friends
Under active
Sucks thumb
Wets the bed
Wets / soils clothes
Separation problems
Withdrawn
Shy
Won't sleep in own bed
Imaginary friends

Speech difficulties
Nervous habits
Acts before thinking
Short attention-span
Unable to sit still
Clowns a lot
Grinds teeth
Worries a lot
Afraid / fearful
Seems insecure
Bangs head

Difficulty keeping friends
Disrespectful / argumentative
Temper tantrums
Ignores rules / chores
Defies authority
Threatening behavior
Throws / breaks things
Fighting
Sets fires
Steals
Breaks curfew
Runs away
Skips school
Doesn't complete schoolwork
Has problematic friends
Looks high often

Other ____

Has your child ever been in therapy before? ______
When was your child in therapy? ____
Who was the therapist____
Where ____
How long did your child stay in therapy?_____________________________________
Whose idea is it for your child to be in therapy now ?__________________________

Family :
Please list the complete family unit and specify any step siblings / step parents

Name	Age	Relationship to you

Current Parental Marital Status:__________________ Age first married__________
times married ___________# times divorced ________# times widowed________

Who is your child being raised by ____

Please describe what you see the issues are? _________________________________
____
____
____

Legal Involvement
Is your child in any legal trouble?_____ If so, for what?________________________
Is your child on probation?____________________________
If so, who is their probation officer? ____
Address:____
Phone #:____

Education
What Grade is your child in? _______________________________
School____
School Address ____
____

Teacher___________________________ Counselor _____________________________

Does your child have a learning disability? __________________
In Special Education classes? ______________________________
What is your child's attendance like?_________________________
What is your child's behavior like at school? _________________________________
____What is your child's grades like in school?

Employment
Is your child employed?___________ How many hours? _______________________
What type of work do you do?____
Where?____
What type of work does your partner do?_____________________________________
Where?____
Do you have any work problems now?__________
If so, what____
Do you have any Financial Problems:__________

What is your **ethnic/cultural** background?____________________
Any concerns?____

What is your **religious/spiritual** involvement?___________________
Any concerns?____

Do you have any concerns about your child regarding:
Sexuality issues? ____
Gender issues? ____

Suicide / Homicide Risk

Is your child thinking about suicide now?_________
Has he/she ever thought about suicide?________ How many times? ______________
Has he/she ever attempted suicide? ___________ How many times? ______________
If so, when?____
What did you do?____
How did others react?____
What help did your child get?____

Is your child thinking about homicide now? __________________________________
Has your child ever thought about homicide? _________________________________

Has your child ever harmed animals? ___________
Has your child ever seriously harmed other children?_______________________
Has your child played with fires?____
Has your child smeared feces?____

Has your child ever been hospitalized for emotional reasons?__________________
If so, when?_______________________ How many times? _______________________

Which hospital? ____
For how long?____
What event brought your child to the hospital? __________________________

Abuse Issues
Has your child witnessed domestic violence?_________ if so, at what ages______
Has your child experienced physical abuse?__________ if so, at what ages_____
Has your child experienced emotional abuse?_________ if so, at what ages_____
Has your child experienced verbal abuse? ___________ if so, at what ages_____
Has your child experienced sexual abuse? ___________ if so, at what ages _____

Are you afraid of your partner?__________
Is your partner afraid of you?___________
Do you get into physical fights with your partner? _______

How do you discipline your children?________________________
How does your partner discipline the children?_________________
Has protective services ever been called?______________________
If so, when____________ For what reason___________________________
How many times have they been called?_________
Is Protective Services involved now?___________

Has the child's mother ever been a victim of:
Physical abuse?_______ by whom_____________________ at what ages_____
Emotional abuse?_____ by whom _____________________at what ages _____
Sexual abuse?_________ by whom _____________________at what ages _____

Has the child's father ever been a victim of:
Physical abuse?_______ by whom_____________________ at what ages_____
Emotional abuse?_____ by whom _____________________at what ages _____
Sexual abuse?_________ by whom _____________________at what ages _____

Health
How is your child's physical health currently? _______________
Current Medical problems (please explain in detail _________________________

What medical problems has your child had in the past (please explain in detail)____
____
____

Has your child had any surgeries (please explain in detail)
____
____
____

Primary Doctor:______________________________

Phone Number: ______________________________

Address:____

____

What medications is your child taking for ………. (list dosage and frequency)

Medication Dosage/freq Prescribed by Helps with
____
____
____
____
____

Developmental History
Was your child's developmental milestones all within normal limits? _____________
What was delayed? ____

What is delayed now? ____

Parental Alcohol Use – You (Mother/ Father)
What alcohol do you drink?______________________________
How much do you drink?_________________ How often do you drink?___________
Do you think your alcohol use is a problem for you?________
Have you ever tried to cut down or stop?___________________
What happened?____
Have you ever been in treatment for your alcohol use?_______
Has Alcohol ever been a problem for you in the past?____________
What drugs do you use currently? ____________________________
What drugs did you use as a teenager? ______________________________

What is your attitude about teen Alcohol and drug use?______________________

Parental Alcohol Use – Spouse (Mother / Father)
What alcohol does your spouse drink?______________________________
How much does your spouse drink?_________________ How often do your spouse drink?____________
Do you think the alcohol use is a problem?________
Has your spouse ever tried to cut down or stop?___________________
What happened?____
Has your spouse ever been in treatment for alcohol use?_______
Has Alcohol ever been a problem for your spouse in the past?____________
What drugs does your spouse use currently? ____________________________
What drugs did your spouse use as a teenager? ______________________________
What is your spouse's attitude about Teen Alcohol and drug use? ______________

Child's Alcohol Use

Does your child drink?_________ if so, since what age_____________
What does your child drink?____________________________________
How much does your child drink?________________________________
How often does your child drink?________________________________
What drugs has your child tried?____________________________________
What drugs does your child use now? ________________________________
How much do your child use?_____________________________________
How often does your child use?______________________________________
Do you think your child's drug use is a problem?______________

Does anyone in your immediate or extended family have a problem with:

Alcoholism________ if so, whom ___________________________________
Drug use __________ if so, whom ___________________________________

Has anyone in your immediate or extended family ever:

Attempted suicide ______ if so, whom ______________________________
Committed suicide ______ if so, whom ______________________________
Attempted homicide _____ if so, whom ______________________________
Committed homicide _____ if so, whom ______________________________

Has anyone in your immediate or extended family have difficulties with:

Depression _________ if so, whom _________________________________
Anxiety/panic attacks _____ if so, whom ____________________________
Manic Depression/Bipolar _____ if so, whom _________________________
Other ____

Parent Signature ________________________________ Date: _____________

Therapist Signature ______________________________ Date: _____________

(revised 3/2107) ws pdf

Teen Self Report

Your name: ________________________________ Date: _____________________
Age: _________________ Birthday: _______________

How do you feel about coming to therapy? ___________________________________
____
____
__

Whose idea is it for you to come to therapy? _________________________________

What does your family think the problem is? _________________________________

What do you think the problem is? ____

What grade are you in? ___________________
Name of School_________________________________
What grades are you getting? ____
What do you like about school? ____
What don't you like about school? ____
Do you work?___________ How many hours? ________ Do you like work? ________
Where do you work? _______________________________________

What do you like about yourself? ____
What does your family like about you? ______________________________________
What does your friends like about you? ______________________________________

What do you like doing? ____

What makes you angry / mad? ____
What upsets you the most? ____
What do you hate doing? ____

What makes you feel sad? ____
What makes you feel scared? ____
What do you worry about? ____

Who are you closest with in your family? ____________________________________
Who don't you get along with in your family?__________________________________
What don't you like about yourself? ____
Have you ever thought about running away? __________________________________
Have you ever thought about hurting yourself? _______________________________
Have you ever hurt yourself or attempted suicide? _______________ if so, please explain what you did____
____
____
__

Have you ever seriously hurt anyone else? ____________________ if so, please explain____
____
__

Have you ever wished you were never born? ____________
Have you ever felt unwanted or that your family wants to get rid of you __________
Who?____

Have you ever hurt animals? ____
Do you set fires? ____________________
Are you in a gang? __________________

Are you in trouble with the law? _______________ what did you do? _____________
____
_
Are you on probation? _______________________
How many times have you been in trouble with the law? _____________________

Have you ever been in therapy before? _______________________________________
What was helpful?____
What wasn't helpful? ____

Are you sexually active? _____________ since what age? _______________________
Do you use protection? ______________ Does your parents know? ______________
Do you have any sexual concerns now? _____________________________________

Do you drink? _______ since what age? _________________
How often do you drink? ______________________________
How much do you drink? _____________________________
What do you drink? __________________________________
Do your parents know? ______________________________

What drugs have you ever tried –please circle

Marijuana Cocaine LSD Ecstasy Speed Heroin

Others ____

What do you use now? ____
How often do you use? ____
How much do you use?____
Do your parents know? ____

Teen Signature: __________________________________ Date: _________________

(revised 3/2017) ws pdf

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Therapeutic Approaches

General Psychotherapy

Robin Kahler, LMSW provides psychotherapy to children, teenagers and adults. Therapy might draw from a variety of therapeutic approaches including cognitive behavioral, marital, EMDR and Sensorimotor Psychotherapy.

EMDR

Eye Movement Desensitization Reprocessing is a trauma therapy involving bilateral stimulation, either by using eye movement, sound or sensation. This can help process trauma by stimulating the two brain hemispheres to work together, helping traumatic memory to be recalled and processed through. If you have had seizures, take anxiety medication, or wear progressive lenses, please discuss this first with the therapist. This treatment helps soften and release memories so they are not as painful. If you are to testify in court regarding a trauma, this treatment might make recalling details of the memory difficult and in that way may affect your court case. It is important to not schedule any important events involving decision making or driving following treatment sessions, until we know how these treatments affect you. As with any intervention there are possible risks involved. Here is a link on Web MD that describes the technique **http://www.webmd.com/mental-health/emdr-what-is-it#1**

Sensorimotor Psychotherapy

Sensorimotor Psychotherapy is a form of talking therapy that brings mindfulness to the body sensations, tensions, posture, movements and emotions. In doing so it is a body oriented psychotherapy for the treatment of trauma, attachment wounding and attachment trauma. Here is an article from one of the teachers, talking in depth about the process of Sensorimotor Psychotherapy **http://www.janinafisher.com/pdfs/trauma.pdf**

Trauma involves the body's nervous system to respond to a threat, causing a fight or flight response. This causes feelings of panic, rage or exhaustion. Incidents that can cause trauma include car accidents, house fires, being in combat, etc.

Attachment trauma also causes the nervous system to go into survival mode, but is complicated by the fact that the threat is coming from a significant attachment figure, like a parent. Examples might include physical, sexual abuse or neglect.

Attachment wounding can be emotionally painful, but does not cause our nervous system to go into a survival response. One may feel anxiety but it doesn't spike into panic for example. Attachment wounding might include things like feeling criticized, teased, or put down.

Sensorimotor Psychotherapy treatment might include physical touch as part of the therapy. This is always optional and your therapist will ask permission each time. There are risks involved with touch such as possibly activating old memories or increasing a longing for contact. If touch is considered appropriate part of your treatment, you will always have the right to decline without any fear of adverse consequences. An example of how touch might be included in therapy could be the therapist offering a little resistance to your hands as you explore the need to push something or someone away.

Client: I acknowledge and agree to:

I have read and understand risks are involved in the treatment of trauma, such as reactivation of memory and symptoms, and will discuss any concerns with the therapist ahead of time.

I understand that the therapist may use physical touch as part of the therapeutic approach, provided I give permission orally each time. I will ask questions concerning touch at any time during the course of my therapy. I also will agree to notify the therapist if I do not wish to use touch as part of treatment.

I understand with children or adolescents, all physical intervention, if at all, will be performed by the parent and/or with the parent in the room.

I understand that the use of touch might bring about increased longing for contact. I understand that sexual contact between therapist and client is never appropriate. I also understand that the therapist will hold appropriate boundaries, and will avoid dual relationships.

______________________________	______________________________
Client or Parent's Signature	Date
______________________________	______________________________
Client Name (Print)	Child's Name
______________________________	______________________________
Robin Kahler, LMSW	Date

Robin Kahler, L. M.S.W., A.C.S.W.
1817 W. Stadium, Suite I, Ann Arbor, MI 48103
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Consent for Therapy & Payment Agreement Form

I, ___________________________________ voluntarily consent to psychotherapy, and understand that I can discontinue from therapy at anytime. I also understand that it is my responsibility to pay for all therapy, either through insurance coverage or private pay and agree to pay at the time of each session. I agree to notify Robin Kahler, LMSW, if there are any changes in my insurance coverage, if there are multiple insurances or if my policy is terminated. In the event the insurance company does not pay for services, I agree to make payments in full. I understand that the therapy time is reserved for me and will make every effort to keep my appointments. In the event I need to cancel an appointment, I agree to do so at least 48 hrs. in advance, or will pay the full fee (which is not covered by insurance companies). Exceptions are made for emergencies. If you are using an Employee Assistance Program (EAP) then you will need to obtain authorization through the EAP.

initial_______ I also agree to provide credit card information and give permission to have it safely stored in Therapy Notes or their credit card associates as part of the electronic medical record. I understand and provide permission to have any missed appointments or other fees not paid at the time of service to automatically be charged to this credit card.

initial_______ I understand that Robin Kahler, LMSW reserves the right to send any outstanding balances that are exceeding 90 days to a collection agency.

initial_______ I understand that all clinical information is confidential and will not be disclosed, unless a signed release is authorizing disclosure. Exceptions are; you are threatening to harm yourself or another, there is suspicion of child abuse or neglect, when you are in a medical emergency, a court order

initial_______ I, understand that I can be terminated from therapy and referred elsewhere for the following reasons: Acting in a violent or hostile manner, carrying a weapon to sessions, attending sessions intoxicated, not paying the fees timely.

initial_______ I authorize Robin Kahler to submit bills and necessary clinical information to my insurance or EAP companies for the purpose of receiving reimbursement, authorization or audit reviews. I consent for electronic billing whenever possible, either through insurance/EAP websitesor through Therapy Notes, Inc and their clearing house. I understand these are HIPAA compliant companies. I also understand that Robin Kahler, LMSW might hire an individual or billing service to assist in billing.

initial_______ I also understand that my medical record will be kept electronically through Therapy Notes, a HIPAA compliant company. I understand that if any HIPAA breaches occur, I will be notified.

Initial_______ I consent permission to communicate with the therapist via technology and in doing so give consent for medical record information or personal health

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Consent for Therapy & Payment Agreement Form (pg2)

information to be transmitted in this way. I understand the risks involved if I choose to send an email or text to the therapist and expect a reply.

By signing, I acknowledge that I have read and agree to the above statements.

_______________________________ ______________
Client Signature or Parent Signature Date

____
Childs name if client

_______________________________ ______________
Therapist/Witness Signature Date

Robin Kahler, L.M.S.W., A.C.S.W.
1817 W. Stadium, Ste I, Ann Arbor, MI 48103
(734) 645-0580

Client Name: ________________________ **Social Security** _________________________

Date of Birth: _______________________**Age:**__________________A_________

Address:____

____

Cell phone #: ____________________ **Home phone #:** _________________________

Email:__________________________________

Emergency Contact: _______________________________________**Relationship:**____________

Phone#: ______________

Insurance Company: __________________ **Policy Holder's phone #:** __________________________________

Policy holder Name: _________________ **Date of birth:** ______________________________

Contract #: __________________________ **Group #:** __________________________________

Employer: ___________________________

Deductable _______**Copay** _______

Secondary Insurance:_____________________ **Date of Birth:**________________________________

Policy holder Name:________________________

Contract #:_______________________________ **Group#:** ____________________________________

Employer: _______________________________

Deductible: ______________________________ **Copay:** ____________________________________

Who referred you: ____**(revised 3/2017) 3/6**

Robin Kahler, L.M.S.W., A.C.S.W.
1817 W. Stadium, Suite I, Ann Arbor, MI 48103 (734) 645-0580

Authorization for Release/Request of Client Information

I, ______________________(client/parent) whose date of birth is _____________ hereby authorize
Robin Kahler LMSW, ACSW, 1817 W. Stadium, Suite I, Ann Arbor, MI 48103 to disclose to and or obtain client records from (write in Insurance company or EAP)

____

I, authorize the following information to be released: assessment, intake paperwork, demographic information, diagnosis, psychosocial evaluation, psychological evaluation, treatment plan and updates, medication, participation in treatment, medical information, educational information, discharge summary, continuing care planning, progress in treatment, progress notes. For the purpose of:
(***please put your initials in **ONE)**
___ Insurance Communication to coordinate billing
___ EAP Communication to coordinate billing

I further understand that Robin Kahler, LMSW will not condition my treatment on whether I give authorization for the requested disclosure.
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations, unless a State Law applies that is more strict than HIPAA and provides additional privacy protections.

This consent automatically ends when its purpose has been achieved, or 60 days after the date below, whichever is later.

____ ____________________
Client Name Date

____ ____________________
Parent Signature Date

____ ____________________
Therapist Signature/Witness Date

****

(*DO NOT SIGN HERE UNLESS YOU ARE REVOKING THE RELEASE)**
I understand that I can revoke this release at anytime. By signing here, I am canceling this release. Signed____________________ dated ___________ updated release 3/2017 -4/6

Robin Kahler, L.M.S.W., A.C.S.W. 1817 W. Stadium, Suite I, Ann Arbor, MI 48103
(734) 645-0580

Authorization for Release/Request of Client Information

I, ____ whose date of birth is ______________
hereby authorize Robin Kahler LMSW, ACSW, 1817 W. Stadium, Suite I, Ann Arbor, MI 48103 to Disclose to and or obtain client records from
Primary Doctor -____
Doctor's Address____
Doctor's Phone: ____________________________ Fax:____________________________

I, authorize the following information to be released: assessment, intake paperwork, demographic information, diagnosis, psychosocial evaluation, psychological evaluation, treatment plan and updates, medication, participation in treatment, medical information, educational information, discharge summary, continuing care planning, progress in treatment, progress notes. This release is for or the purpose of communicating to coordinate treatment. I further understand that Robin Kahler, LMSW will not condition my treatment on whether I give authorization for the requested disclosure.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations, unless a State Law applies that is more strict than HIPAA and provides additional privacy protections.

This consent automatically ends when its purpose has been achieved

____ ___________________________
Client Name Date

____ ___________________________
Client/Parent Signature Date

____ ___________________________
Therapist Signature/Witness Date

****

(***DO NOT SIGN HERE UNLESS YOU ARE REVOKING THE RELEASE)
I understand that I can revoke this release at anytime. By signing here, I am canceling this release. Signed____________________ dated ___________ updated release
(revised 3/2017) 5-6

Robin Kahler, LMSW
1817 W. Stadium, Suite I, Ann Arbor, MI 48103
(734) 645-0580

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name:_______________________________________

DOB: ____

SSN:____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Robin Kahler, LMSW Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Robin Kahler, LMSW at (734) 645-0580.

____

Signature of Patient/Client Date

____

Signature or 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