



**Robyn Howisey, MA, LMFT**  
Counseling for Children, Teens & Adults

2319 N. 45th Street #102  
Seattle WA 98103  
206.851.8276

www.thriving-child.com

## Teen Client Information

All information will be kept confidential.

Today's Date: \_\_\_\_\_

Client (Teen) Name: \_\_\_\_\_

### Parent Information

Parent/Guardian Name(s): \_\_\_\_\_

(May I leave a message at number?)

Home: \_\_\_\_\_ Y N      Work: \_\_\_\_\_ Y N

Cell: \_\_\_\_\_ Y N      \_\_\_\_\_: \_\_\_\_\_ Y N

Email: \_\_\_\_\_ can I email you? Y N

How do you prefer to be contacted? \_\_\_\_\_

### Teen Information

**Name:** \_\_\_\_\_ Birth date: \_\_\_\_\_

(May I leave a message at number?)

Home: \_\_\_\_\_ Y N      Work: \_\_\_\_\_ Y N

Cell: \_\_\_\_\_ Y N      \_\_\_\_\_: \_\_\_\_\_ Y N

Email: \_\_\_\_\_ can I email you? Y N

How do you prefer to be contacted? \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Can I send mail here if needed? Y N

### Insurance Information

Client's Relation to Insured?  Self  Spouse  Child  Other

Subscriber's Name (if not self) \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Co payment \$ \_\_\_\_\_

Person to contact in case of emergency:

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

May I call and thank them? Y N

## Client (Teen) Intake

Teen Name: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Birth Place: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

How are you doing in school? \_\_\_\_\_

Do you like school? \_\_\_\_\_

Other activities involved in: \_\_\_\_\_

Current Living Situation (i.e. full time one home, one week with mom/one with dad, etc.)

\_\_\_\_\_

Name of Primary Care Physician? \_\_\_\_\_

Have you (child/teen) ever been in counseling? Y N If Yes, when? \_\_\_\_\_

Counselor's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_

Was it helpful? \_\_\_\_\_

Please list any medications (prescription or non-prescription) you are currently taking:

Name	Dose	Reason	Length of Time on

Siblings (if any):

First Name	Age	Gender	Full/half/step sibling?	Living with you?

Please list any important people (other than biological parents) in your life:

\_\_\_\_\_

\_\_\_\_\_

## Parent Information

**Mother's** Name: \_\_\_\_\_ Current Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Education: \_\_\_\_\_  
Place of Birth: \_\_\_\_\_ Religious Affiliation (if any) \_\_\_\_\_  
History of mental illness? Y N \_\_\_\_\_  
History of drug/alcohol abuse? Y N \_\_\_\_\_  
Relationship Status: single married divorced separated in relationship \_\_\_\_\_  
Who lives in this household? \_\_\_\_\_  
How is relationship between you (teen) and your mom? \_\_\_\_\_  
\_\_\_\_\_

**Father's** Name: \_\_\_\_\_ Current Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Education: \_\_\_\_\_  
Place of Birth: \_\_\_\_\_ Religious Affiliation (if any) \_\_\_\_\_  
History of mental illness? Y N \_\_\_\_\_  
History of drug/alcohol abuse? Y N \_\_\_\_\_  
Relationship Status: single married divorced separated in relationship \_\_\_\_\_  
Who lives in this household? \_\_\_\_\_  
How is relationship between you (teen) and your dad? \_\_\_\_\_  
\_\_\_\_\_

Why are you seeking help?

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Feel free to write anything else you'd like me to know on an additional piece of paper, or on the backside of this one.

Thank You.



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Greetings. Please take a moment to read the next few pages, as they will give you more information about me, the way I work, your (and/or your child's) therapy and treatment, as well as your rights and responsibilities as a client. If you have any questions or concerns about anything, please do not hesitate to ask.

### **Education and Experience:**

I am a Licensed Marriage and Family Therapist (License# LF60090906) in Washington State. I am an Associate Member of the American Association of Marriage & Family Therapy, as well as a member of the Washington State Association of Marriage and Family Therapy.

I have my MA degree in Psychology with a specialized concentration in Child, Couple and Family Therapy. Prior to private practice, I worked in community mental health, where the majority of my time was spent working with young children with behavioral issues. I have led groups for Parents of Explosive Children, and co-led adult DBT (Dialectical Behavior Therapy) groups. Currently in my private practice I work with children, teens, and adults.

### **Areas of Special Focus & Approach:**

My areas of special focus include depression, anxiety, perfectionism, and angry/explosive children. I believe that therapy is a collaborative process between client and therapist. Our work will help you and/or your family process emotional and communication issues, to foster insight and growth. In my work with children, I use play therapy, sand tray, and games to facilitate the therapy process. I work with a range of emotional and behavioral issues. I also specialize in children with unique sensitivities and intuitive abilities. My goal is to bring out strengths, teach skills when necessary, develop insight and help guide to a place of healing and wholeness.

I cannot and do not prescribe medication. I prefer to attempt alternative methods before turning to medication. I may have suggestions for supplements that may benefit your child. Please do your own research, as I am not a naturopath or physician and would merely be offering a suggestion. If medication seems appropriate, I would be happy to talk to your (and/or your child's) primary care physician to determine the next course of action. If you (and/or your child) are already on medication, please continue taking them.

### **Fees and Payment:**

I am a provider with Premera Blue Cross Insurance and will bill them for you. You will be required to pay your co-pay at the time of services as well as any other services that your insurance does not cover. For all other insurance carriers I am considered an out-of-network provider. Payment is due at the time of service by cash/check/credit card. On the 5<sup>th</sup> of the following month you will receive an automatic statement via email which you can submit to your insurance company. I cannot guarantee your insurance company will reimburse you for counseling services.

Sessions are 50 minutes long. Please be on time to make the most of your session. If you are late, your appointment will not extend beyond your scheduled time. Please provide at least 24 hours notice if you need to cancel, or you will be billed at a full session rate (this applies even for a sick child).

### **Review of Records:**

I keep a record of the services that I provide to you (and/or your child). It is your right as a client to see and have a copy of your records at any time. You may also ask to correct that record. The request of a copy of your records must be submitted in writing and I may charge a reasonable photocopying fee. As a parent, in general, you are entitled to information about your child but this is different from a right to access their records. If your child is under the age of 13, you have a right to see his/her records. If your child is 13 or over, a signed release of information must be obtained from your child before his/her records can be released.





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## Credit Card Payment Authorization

Please enter your credit/debit card information. **Please complete this form even if you will be using insurance.** This card will be charged for co-pays (if you wish), no shows and late cancels, as well as services not covered by insurance.

**Client Name:** \_\_\_\_\_

### Card Holder Information associated with credit/debit card:

Card Holder Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email where you wish statements/receipts to be sent:

\_\_\_\_\_

### Credit/Debit Card Information:

Card Type: Visa MC Discover

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please note the vendor will read "Therapy Partner" on your credit/debit card statements. Statements are automatically emailed on the 5<sup>th</sup> of the following month from Therapy Partner and can be submitted to your insurance if applicable.

## Directions to Wallingford Office for Robyn Howisey, MA, LMFT

Wallingford Work Spaces

2319 N. 45<sup>th</sup> Street

#102

Seattle, WA 98103

206.851.8276

### **Driving Directions:**

From I-5 North or South take the NE 45<sup>th</sup> Street Exit (Exit 169). Head West on 45<sup>th</sup>. After a few blocks (past Dick's burgers) turn left onto Sunnyside Ave N. Wallingford Work Spaces are on Sunnyside, just behind the building on the corner of 45<sup>th</sup> and Sunnyside.

### **Parking:**

There is 1 hour parking along 45<sup>th</sup>, and ample residential parking along Sunnyside, 44<sup>th</sup> and throughout the neighborhood behind Wallingford Work Spaces. **Please be aware there is no parking on Sunnyside after 5pm – signs are posted.**

### **Entering the Building:**

Wallingford Work Spaces are just behind (south of) the Loski apartment building. From Sunnyside, go up the stairs between the two brown buildings with red trim. To the left you will see a sliding glass door and "Wallingford Workspace Waiting Room" sign. Please wait in the waiting room and I will come get you at the time of your session.

If your appointment is after 6 pm the building will be locked. You will need to use the keypad at the exterior door on Sunnyside - search Howisey. Please note, if you are more than 10 minutes early for your session, I may still be in session and not able to buzz you in immediately. Once buzzed in, go up the stairs to the first floor. The waiting room is down the hall to the right.