Intake Form—Children and Adolescents (<18)

PATIENT INFORMATION

Full Name (First, MI, Last):________________________________ Sex: Male___ Female___

Address:____ Birthdate:______________

City:_______________________ State:______ Zip:_________ Soc. Sec.#_____-___-____

Home Phone: ______________ Cell:_______________ Work:_____________

Grade Level:______________________ Name of School:____________________________

How did you find Dr. Ward? (Phonebook, Website, Friend/Family, Referred, Other)

If referred, by whom?___________________________

RESPONSIBLE PARTY (If Minor) OR EMERGENCY CONTACT

Full Name:_____________________________ Home Phone:___________________

Address:__________________________________ Cell or Work Phone:________________

City: _______________________ State:_______ Zip:________

Relationship to Patient:______________________

INSURANCE COMPANY INFORMATION – POLICY HOLDER

Name of Insurance:______________________ Contact # for Insurance:___________________

First Name:_______________ MI:_____ Last Name:_________________________________

Address:____________________________________ Home Phone:_____________________

City:_________________ State:_____ Zip:_______ Work/Cell Phone:__________________

Birthdate:________________ SS#:____-____-_______ Sex: Male____ Female____

What is your relationship to the policy holder? Spouse____ Child_____ Self_____ Other_____

Employers Name:__________________ Is this your employer's health plan? Yes____ No____

Is your signature on file?_________ Will this be covered by an EAP program? Yes____ No____

EAP contact name:_____________. What is your EAP Authorization Number?______________

If there is another Health Benefit Plan, please complete another intake form and write "Secondary Insurer" on the top of the form.

AUTHORIZATION SIGNATURES (insured's or other authorized persons)

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party below.

Signed:____________________ Date:________

I authorize payment of medical benefits to the undersigned physician or supplier for services.

Signed:_________________ Date:_______

Please Complete This Form as Thoroughly as Possible

Primary reason(s) for seeking services:

__ Anger management ____ Anxiety ____ Coping ____ Depression
__ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns
__ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs ____ Hyperactivity
__ Other mental health concerns (specify): ____

____

What are your goals for the child's therapy? ____

____

What family involvement would you like to see in the therapy? ______________________________

____

Do you believe the child is suicidal at this time? _________________ Yes _________ No
If Yes, explain: ____

____

Have there been any other significant changes or events in your child's life? (family,death, moving, fire, etc.)
__ Yes ____ No If Yes, describe: ____

____

Family History

Parents

With whom does the child live at this time? ____
Are parent's divorced or separated? ____
If Yes, who has legal custody? ____
Were the child's parents ever married? ____ Yes ____ No
Are both parents in agreement with counseling? ____ Yes ____No ____Unknown
If a custody arrangement exists, please explain the arrangement: ______________________________

____

If there is a legal custody arrangement for the child, a copy of the custody agreement must be submitted in order to treat the child in counseling

Client's Mother

Name: ______________________ Age: _____ Occupation: ______________ ____ FT ____ PT
Where employed: ____________________________ Work phone: _____________________
Is there anything notable, unusual or stressful about the child's relationship with the mother?
__ Yes ____ No If Yes, please explain: ____

____

How is the child disciplined by the mother? ____
For what reasons is the child disciplined by the mother? ______________________________________

Client's Father

Name: ______________________ Age: _____ Occupation: ______________ ___ FT ___ PT

Where employed: ____________________________ Work phone: ____________________

Is there anything notable, unusual or stressful about the child's relationship with the father?

__ Yes ___ No If Yes, please explain: ____

____

How is the child disciplined by the father? ____

For what reasons is the child disciplined by the father? ______________________________

Step Parent (If Applicable)

Name: ______________________ Age: _____ Occupation: ______________ ___ FT ___ PT

Where employed: ____________________________ Work phone: ____________________

Is there anything notable, unusual or stressful about the child's relationship with the Stepparent?

__ Yes ___ No If Yes, please explain: ____

____

How is the child disciplined by the stepparent? _____________________________________

For what reasons is the child disciplined by the stepparent? ___________________________

Step Parent (If Applicable)

Name: ______________________ Age: _____ Occupation: ______________ ___ FT ___ PT

Where employed: ____________________________ Work phone: ____________________

Is there anything notable, unusual or stressful about the child's relationship with the Stepparent?

__ Yes ___ No If Yes, please explain: ____

____

How is the child disciplined by the stepparent? _____________________________________

For what reasons is the child disciplined by the stepparent? ___________________________

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_________________	____	____ F ____ M	____ home ____ away	____ poor ___ average ___ good
_________________	____	____ F ____ M	____ home ____ away	____ poor ___ average ___ good
_________________	____	____ F ____ M	____ home ____ away	____ poor ___ average ___ good
_________________	____	____ F ____ M	____ home ____ away	____ poor ___ average ___ good

Others living in the household			Relationship (e.g., cousin, foster child)	
_________________	____	____ F ____ M	__________________	____ poor ___ average ___ good
_________________	____	____ F ____ M	__________________	____ poor ___ average ___ good

Comments: ____

____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

____ Allergies	____ Deafness	____ Muscular Dystrophy
__ Anemia	____ Diabetes	____ Nervousness
__ Asthma	____ Glandular problems	____ Perceptual motor disorder
__ Bleeding tendency	____ Heart diseases	____ Mental Retardation
__ Blindness	____ High blood pressure	____ Seizures
__ Cancer	____ Kidney disease	____ Spinal Bifida
__ Cerebral Palsy	____ Mental illness	____ Suicide
__ Cleft lips	____ Migraines	____ Other (specify): ________
__ Cleft palate	____ Multiple sclerosis	__________________________

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? ___ Yes ____ No

If Yes, describe: ____

Mother's age at child's birth: ______ Father's age at child's birth: ______

Child number ____ of __ total children.

While pregnant did the mother smoke? ____ Yes ____ No If Yes, what amount: ______________

Did the mother use drugs of alcohol? ____ Yes ____ No If Yes, type/amount: ______________

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) ____ Yes ____ No

If Yes, describe: ____

Baby's birth weight: ________________ Baby's birth length: ____________________

Describe any physical or emotional complications during or after delivery: _______________________

____

Infancy/Toddlerhood Check all which apply:

__ Breast fed	____ Milk allergies	___ Vomiting	____ Diarrhea
__ Bottle fed	____ Rashes	___ Colic	____ Constipation
__ Not cuddly	____ Cried often	___ Rarely cried	____ Overactive
__ Resisted solid food	____ Trouble sleeping	___ Irritable when awakened	____ Lethargic

Developmental History

Describe any notable delays or concerns regarding your child's physical, mental, social, or emotional development:

____

____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

____

____

Education

Current school: ______________________________ School phone number: ____________________

Type of school: ____ Public ____ Private ___ Home schooled ____ Other (specify): ____________

Grade: _______ GPA:________ Teacher: ______________School Counselor: _________________

In special education? ____ Yes ___ No If Yes, describe: ________________________________

In gifted program? ___ Yes ____ No If Yes, describe: ________________________________

Has child ever been held back in school? ____ Yes ____ No If Yes, describe: __________________

Have there been any recent changes in the child's grades? __ Yes ____ No

If Yes, describe: ____

Has the child been tested psychologically? ____ Yes ____ No

If Yes, describe: ____

If an "IEP" exists, please explain:____

____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

___ Anxious ____ Passive ____ Enthusiastic ____ Fearful

___ Eager ____ No expression ____ Bored ____ Rebellious

___ Other (describe): ____

Approach to School Work:

___ Organized ____ Industrious ____ Responsible ____ Interested

___ Self-directed ____ No initiative ____ Refuses ____ Does only what is expected

___ Sloppy ____ Disorganized ____ Cooperative ____ Doesn't complete assignments

___ Other (describe): ____

Performance in School (Parent's Opinion):

___ Satisfactory ____ Underachiever ____ Overachiever

___ Other (describe): ____

Child's Peer Relationships:

___ Spontaneous ____ Follower ____ Leader ____ Difficulty making friends

___ Makes friends easily ____ Long-time friends ____ Shares easily

___ Other (describe): ____

Who handles responsibility for your child in the following areas?

School: ____ Mother ____ Father ____ Shared ____ Other (specify): _____________

Health: ____ Mother ____ Father ____ Shared ____ Other (specify): _____________

Problem behavior: ____ Mother ____ Father ____ Shared ____ Other (specify): _____________

Leisure/Recreational/Work

Describe special areas of interest or hobbies or after-school work (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?

Please describe any concerns about this subject:

____\

Medical/Physical Health

List any current health issues: ____

____

List any recent health or physical changes: ____________________________________

____

Name of Primary Care Physician:________________________Phone Number:____________________

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	______________________	____ No __ Low ____ Med ____ High
Lunch	____ / week	______________________	____ No __ Low ____ Med ____ High
Dinner	____ / week	______________________	____ No __ Low ____ Med ____ High
Snacks	____ / week	______________________	____ No __ Low ____ Med ____ High

Comments: ____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ____ Yes ____ No

If Yes, describe: ____

____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	____	____	____________	__________________	_________________
Suicidal thoughts/attempts	____	____	____________	__________________	_________________
Drug/alcohol treatment	____	____	____________	__________________	_________________
Hospitalizations	____	____	____________	__________________	_________________

Behavioral/Emotional

Please check any of the following that are typical for your child:

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries

____ Frustrated easily
____ Gambling
____ Generous
____ Hallucinations
____ Head banging
____ Heart problems
____ Hopelessness
____ Hurts animals
____ Imaginary friends
____ Impulsive
____ Irritable
____ Lazy
____ Learning problems
____ Lies frequently
____ Listens to reason
____ Loner
____ Low self-esteem
____ Messy
____ Moody
____ Nightmares
____ Obedient
____ Often sick
____ Oppositional
____ Over active
____ Overweight
____ Panic attacks
____ Phobias
____ Poor appetite
____ Psychiatric problems
____ Quarrels

____ Sad
____ Selfish
____ Separation anxiety
____ Sets fires
____ Sexual addiction
____ Sexual acting out
____ Shares
____ Sick often
____ Short attention span
____ Shy, timid
____ Sleeping problems
____ Slow moving
____ Soiling
____ Speech problems
____ Steals
____ Stomach aches
____ Suicidal threats
____ Suicidal attempts
____ Talks back
____ Teeth grinding
____ Thumb sucking
____ Tics or twitching
____ Unsafe behaviors
____ Unusual thinking
____ Weight loss
____ Withdrawn
____ Worries excessively
____ Other:
____
____

How are problem behaviors generally handled? ____

____

What are the family's favorite activities? ____

____

What does the child/adolescent do with unstructured time? ____

____

Any additional information that you believe would assist us in understanding your child/adolescent?

____

____

____

Any additional information that would assist us in understanding current concerns or problems?

____

____

____

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to email, cell phone text, or home phone a day before your appointment. You can also schedule online at any time. Once your account is established, you simply visit www.therapyappointment.com. If you want to utilize this service, please complete the following:

Requested Login Name:____________________ Requested Password: ____________________

Your Email address:__________________@______________________________

Your Cell Phone Number:_____-______-_________. Your service carrier:_________________

Where would you like to receive appointment reminders? (check one)

______ via a text message (normal text message rates will apply)

______ via an email message

______via an automated telephone message to my home phone

______ None of the above. I'll remember my appointments on my own. (missed appointment fees will still apply.

Appointment information is considered to be "protected health information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

____   _______________________

Signature   Date