

**HEALTH ASSOCIATES
(CHILD INTAKE)**

CHILD'S LEGAL NAME: _____ **DOB:** ____ / ____ / ____ **AGE:** ____

Last First M.I.

ADDRESS: _____

Street #	City	State	Zip Code
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RACE: _____ **ETHNICITY:** _____ **RELIGIOUS PREFERENCE, IF ANY:** _____

SEX AT BIRTH: M ☐ F ☐ **GENDER IDENTITY:** _____ **PRONOUNS:** SHE/HER ☐ HE/HIM ☐ OTHER ☐

SCHOOL: _____ **GRADE:** _____ **CHILD'S SOCIAL SECURITY #:** _____

CHILD LIVES WITH: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER: _____

MOTHER'S NAME: _____ **FATHER'S NAME:** _____

ADDRESS _____ ADDRESS: _____

HOME PHONE #: _____ HOME PHONE #: _____

CELL PHONE #: _____ CELL PHONE #: _____

EMPLOYER: _____ EMPLOYER: _____

WORK ADDRESS: _____ WORK ADDRESS: _____

SOCIAL SECURITY #: _____ **SOCIAL SECURITY #:** _____

PERSON ACCOMPANYING CHILD: _____ RELATIONSHIP: _____

IF YOU WANT INSURANCE CLAIMS FILED, PLEASE COMPLETE:

NAME OF POLICY HOLDER: _____ **POLICY HOLDER DOB:** ____ / ____ / ____

ADDRESS (IF DIFFERENT FROM ABOVE): _____

POLICY HOLDER'S EMPLOYER: _____ **INSURANCE COMPANY:** _____

INSURANCE CARD ID #: _____ **GROUP #:** _____ **RELATIONSHIP TO PATIENT:** _____

Insurance assignment authorization: I authorize the release of treatment data, including drug and alcohol information, for purposes of claims filing, prior authorization, review of medical necessity or any other request for information by my insurance carrier. I also authorize assignment of all medical and mental health benefits payable under my insurance policy to Health Associates LLC so they may be applied to my account. The remainder of all unpaid charges is the responsibility of the patient/legal guardian unless otherwise stated. My signature authorizes Health Associates LLC to process my credit card for any remaining charges not covered by insurance, including missed appointment and/or late cancellation fees (see our office policies for details).

Credit Card #: _____ Exp. Date: _____ Security Code: _____

Signature of Insured/Guardian: _____ **Date:** _____

PLEASE COMPLETE OTHER SIDE

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU ARE CURRENTLY STRUGGLING WITH:**None** = This symptom is not present currently **Mild** = Impacts quality of life, but no significant implication on day-to-day functioning**Moderate** = Significant impacts on quality of life and/or day-to-day functioning **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Headaches	()	()	()	()	Faintness or dizziness	()	()	()	()
Bad dreams	()	()	()	()	Feeling fearful	()	()	()	()
Sweaty palms	()	()	()	()	Weakness in parts of body	()	()	()	()
Shakiness	()	()	()	()	Heart or chest pain	()	()	()	()
Fatigue	()	()	()	()	Feeling tense or nervous	()	()	()	()
Epilepsy	()	()	()	()	Difficulty concentrating	()	()	()	()
Hopelessness	()	()	()	()	Trouble remembering things	()	()	()	()
Overeating	()	()	()	()	Obsessive thoughts	()	()	()	()
Allergies	()	()	()	()	Difficulty staying asleep	()	()	()	()
Worrying/stewing	()	()	()	()	Easily annoyed/ irritated	()	()	()	()
Difficulty making decisions	()	()	()	()	Sadness	()	()	()	()
Lower back pain	()	()	()	()	Muscle tension	()	()	()	()
Tightness in stomach	()	()	()	()	Diabetes	()	()	()	()
Trouble getting breath	()	()	()	()	Crying easily	()	()	()	()
Loss of interest in things	()	()	()	()	Hot flashes	()	()	()	()
Difficulty falling asleep	()	()	()	()	Tightness in jaw	()	()	()	()
Cold hands or feet	()	()	()	()	Grinding of teeth	()	()	()	()
Thoughts of harm to self or others	()	()	()	()	Dry mouth	()	()	()	()
Outburst of temper	()	()	()	()	Feelings of guilt	()	()	()	()

LIST UP TO THREE ISSUES CAUSING YOU THE *MOST* DIFFICULTY:

1. _____ 2. _____ 3. _____

List medications you are presently taking and the dosage: _____

KNOWN ALLERGIES: _____**SUBSTANCE USE: (Daily/Weekly/Monthly/Never)**

Frequency of tobacco use _____

Frequency of illegal drug use _____

Frequency of alcohol use _____