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DEMOGRAPHIC INFORMATION

DATE:

Client Name:	**Home Phone:**
Address:	**Cell Phone:**
	Work Phone:
DOB & Age:	**Email Address:**
SSN:	**Contact Person & Relationship to Client:**
Referral Source:	**Emergency Contact Phone Number:**

INSURNCE & BENEFIT INFORMATION (if applicable)

Insurance Company:	**Provider Services Phone #:**
Insurance ID #:	**Group #:**
Subscriber Name:	**Client Relationship to Subscriber:**
Subscriber DOB:	**Subscriber Employer:**
Subscriber SSN:	**Policy Effective Date:**
Co-pay/Co-Insurance:	**Deductible (Amount met?):**
# Visits Allowed:	**Preauthorization Required?**

CANCELLATION POLICY & OUTSTANDING BALANCES

A 24-hour advance notice is required for cancellation of your scheduled appointment. A missed appointment fee will be charged (varies based on location) to the credit card on file. After 60 days, any unpaid balance will be charged to the credit card on file. You will be refunded for upon the receipt of insurance payments for outstanding dates of service.

CERTIFICATION AND AUTHORIZATION (if applicable)

I certify that the above information is correct. I authorize the release of any medical information necessary to process this claim. I request that payments be made directly to Healthy Minds

Therapy, PLLC on my behalf. Therefore my signature will be on file to file with my insurance company.

_____

Signature of Parent ***Date***

CHILD/ADOLESCENT INTAKE FORM

Child's Name:	Date of Birth:	Age:	Sex:
Race/Ethnicity: o American Indian/Alaskan Native o Asian o Black/ African American o Hispanic/Latino o Hawaiian/Pacific Islander o White/Caucasian o Other _____			
School:		Grade:	
Legal Guardian (s):		Relation to Child:	
Person Filling Out This Form: o Mother o Father o Stepmother o Stepfather o Other _____			
Biological Parents' Marital Status: o Married o Never Married o Partnered o Separated o Divorced o Widowed			

Describe the problem that brings you here today:

Current Symptoms Include (please check all that apply):

- I have no problems or concern bringing me here
- Aggression, violence
- Anger
- Anxiety
- Difficulty concentrating
- Career concerns
- Parenting concerns (your own child)
- Delusions (false ideas/hallucinations)
- Drug or Alcohol Dependence
- Depression
- Divorce/Separation
- Eating problems
- Fatigue/low energy
- Fears, phobias
- Financial problems
- Grief
- Health, medical concerns
- Interpersonal conflicts
- Irritability
- Legal matter problems
- Loneliness
- Martial/relationship problems
- Memory problems
- Mood swings
- Nervousness/tension
- Obsessions/compulsions
- Chronic pain
- Panic or anxiety attacks
- Perfectionism
- School problems
- Self-esteem
- Sexual problems
- Shyness, oversensitive to criticism
- Sleep problems
- Smoking and tobacco use
- Spiritual, moral, religious, ethical issues
- Stress
- Suicidal thoughts
- Thought disorganization and confusion
- Withdrawal or isolation
- Work problems
- Other _____

How long have these difficulties been present?
What are your GOALS for treatment?

MENTAL HEALTH AND MEDICAL HISTORY

Describe any stressors that might be affecting your child now (i.e. death, divorce, trauma):

Has your child been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder, such as Attention Deficit/Hyperactivity Disorder (ADHD), Learning Disorder (LD), Anxiety or Depression? If YES, please specify:

_____

_____

_____

Mental Health History

Has your child received a previous evaluation or intervention? *YES* *NO*

Previous Mental Health Treatment or Evaluation			
Date(s)	**Therapist/Facility**	**Reason for seeking treatment/evaluation**	**Outcome/was treatment helpful?**

Psychiatrist name (if applicable):	
Psychiatrist Address	
Psychiatrist phone#	
Diagnosis:	

Current Medications					
Medication	**Dosage**	**Reason for prescription**	**How long on dication?**	**Prescribing physician**	**Is medication helpful?**

When was your child's most recent medical exam? _____

Does your child have any vision, hearing (including ear infections), speech, or motor coordination problems? If YES, please explain the problem and treatment.

Indicate any significant illnesses/conditions that your child has had and treatment for these conditions.

Has your child ever been taken to the Emergency Room or been admitted to the hospital? If YES, please list why and how old your child was at the time of the visit.

Does your child display any unusual sensitivities to BRIGHT LIGHT, LOUD SOUNDS, or TOUCH? YES OR NO

Does your child have any sleeping difficulties (i.e., trouble falling asleep, staying asleep, waking)? YES OR NO

Does your child have any unusual eating patterns or habits? YES OR NO

HOME INFORMATION

Place of birth: _____ Where raised: _____ Raised by who? _____
Mother's Name: _____ Age: _____ Education: _____ Occupation: _____
Father's Name: _____ Age: _____ Education: _____ Occupation: _____
Stepfather (if applicable) _____ Age: _____ Education: _____ Occupation: _____
Stepmother (if applicable) _____ Age: _____ Education: _____ Occupation: _____

If parents are separated/divorced, who has primary physical custody of the child? _____
Age of child at separation? _____
Describe the current custodial arrangement.
_____
_____
_____

Adults, siblings and/or others living in the family home:

Name	**Age**	**Relationship to child**	**History of problems with behavior, learning, or psychiatric? (i.e. ADHD, depression, anxiety, substance, etc.)**

What was your child's birth order? _____ out of _____.

Is there a family history of mental health issues in the child's biological family? (i.e. ADHD, learning problems, depression, anxiety, bipolar disorder, schizophrenia, substance abuse, etc.)? If YES, please describe:

CHILD'S BIRTH AND DEVELOPMENTAL HISTORY

Were there any problems with the pregnancy or birth of your child? Did the biological mother use any tobacco, medication, street drugs or alcohol while pregnant with this child? If yes, please describe.

Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? If yes, please describe.

EDUCATIONAL HISTORY

Early School Performance

Did you or any teachers have any concerns about your child's early school performance? Please describe:

Please describe your child's significant strengths and weaknesses in his/her academic performance.

Has your child changed schools for reasons other than normal academic progression? Has your child skipped or repeated any grades in school? If YES, when and for what reason?

Recent School Performance

Do you or any teachers have any concerns about your child's recent academic performance?

Has your child's school performance in (or attitude toward) school changed in the last two years? If YES, please explain.

Does your child have any special needs or accommodations at school? Does your child receive any special services at school?

BEHAVIOR

Do you have any concerns regarding your child's behavior either at home, in public or at school? If YES, please explain.

How do you handle discipline in your family? Do you feel these methods are successful in managing your child's behavior?

SOCIAL SKILLS

About how many close friends does your child have? ____ NONE _____ ONE
_____ TWO OR THREE _____ FOUR OR MORE

Please describe any concerns you or others may have regarding your child's ability to get along with other children or your child's ability to interact with adults.

Please list your child's extracurricular activities or social organizations.

Other:

Is there any other information that you think may help me in understanding and working with your child?

My signature below indicates that I have voluntarily and accurately completed this form. A photocopy of this agreement will be considered as valid as an original.

Parent Name **Signature of Parent** **Date**