

Child Intake Paperwork

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Today's Date: (mm/dd/yyyy) _____ Form filled out by: _____
Name: _____ Date of Birth: _____ Age: _____ Gender: _____
Residential Street Address: _____
Primary Phone #: _____ May I leave a message for you at this number? _____
Email address: _____ Is it okay to use email to contact you? _____
Preferred method of contact: _____ Preferred times to contact you if by phone: _____
Legal Guardian(s) (if applicable): _____
Referral Source: _____
Emergency Contact Person(s): _____ Phone #: _____
Emergency Contact Person(s) Relationship to Client: _____

Please fill out lines for the client's family composition including parents, siblings, and blended-family information. Place an asterisk next to the client's name.

Name	Age	Date of Birth	Gender	Family Role

Payment Information

Will you be paying by cash, check, or Venmo? _____
Do you have out of network insurance benefits that might apply? Yes No Unsure

Medical Information

Who is your Primary Care Physician? _____ Phone #: _____
Primary Care Physician's Practice Name/Address: _____

Do you now have, or have you had in the past, any of the following? Check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Serious Accident | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Allergies | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Surgery | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Pregnancy/Miscarriage | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |

Please list any prescription medications you are currently taking: _____

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking: _____

Sleep/Exercise

How has your sleep been the last 7 days? (check all that apply) Restless Difficulty falling asleep. Difficulty staying asleep. Satisfying Refreshing Got enough Other: _____

Mental Health Information

Have you ever been in counseling/therapy before? _____ When? _____
 If yes, what did you find it helpful or effective? _____

Are you currently receiving mental health services? If yes, please list name of practitioner and type of services you are receiving: _____

Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed? _____

Have you ever or are you currently engaging in self-harm? (please circle) Currently Past

Have you ever or are you currently contemplating suicide? Currently Past

Have you ever or are you currently contemplating harming another person? Currently Past

Have you ever attempted suicide? If yes, please fill out 'Other' and include date(s), method(s), and age at time of attempt (please circle): Yes No Other: _____

Do you have a history of abuse/neglect (please explain): _____

Briefly describe why you are coming in for counseling and the goals you hope to achieve in therapy: _____

Family History

Family History of (mark with an 'x' all that apply):

	Mother	Father	Siblings	Grandparents	Aunt/Uncle
Alcohol Substance Abuse:					
History of Completed Suicide					
History of Mental Illness:					
Depression					
Schizophrenia					
Bipolar Disorder					
Alzheimer's					
Anxiety					
Attention Deficit/Hyperactivity					
Learning Disorders					
School Behavior Problems					
Incarceration					
Other					

Comments:					
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Substance Use

Which substances do you currently use or have you previously used? (Mark current with a 'C', Past with a 'P', and 'B' for both current and past):

- None Speed Inhalants Benzodiazepine
- Unknown Cocaine Marijuana Barbiturates
- LCD Caffeine Morphine Methamphetamine
- PCP Heroin Mushrooms Prescription Drugs
- Crack Opioids Alcohol Other (please explain): _____
- Crank Tobacco Amphetamine

Have you ever been in substance abuse treatment? _____ Where/When? _____
Is there a history of substance use in your family? (please explain): _____

Education

Education Level (please check highest level completed):

- Less than 12 years High School Grad/GED Some College or tech school College Graduate Unknown

If still attending, current school/grade: _____ Vocational School/Skill Area: _____

College/Graduate School – Years Completed/Major: _____

Employment

Are you currently employed? (please circle) Yes No

Employer: _____ Profession: _____

Work Phone #: _____ Employer's Address: _____

If you have worked in the past, what did you do for work? _____

Community Involvement

What do you like to do in your free time? _____

What community involvement(s) do you currently have? (ie groups, clubs, activities): _____

Financial Assistance (mark with an 'x' those that apply):

- Food Stamps/EBT TANF SSI SSDI SSA (retirement) Other Retirement Income
- Medicaid Medicare General Assistance

Thank you for filling out this information. It will greatly assist me in our work together.

Acknowledgment of Disclosure Statement

By signing this document, I confirm that I have received a copy of the required disclosure information, and that I have read and understood this information. I agree to participate in and/or have my child(ren) participate in counseling from Heather A. Astill, LCSW, MSW. This agreement shall remain in effect until either the client or the therapist, or both terminate treatment.

_____	_____	_____
Printed Client Name	Client/Legal Guardian Signature	Date
_____	_____	_____
Heather A. Astill, LCSW	Date	

Fee Agreement

I agree to pay the fees as stated in the disclosure statement. (Most commonly: \$140 for intake/60 minute sessions and \$120 for 45-50 minute sessions).

Late cancellations (less than 24 hours notice, unless it is an emergency) and “no-shows” will be billed as half the session fee, and must be paid at the next scheduled appointment or within 15 days, whichever comes first. This will not be billed to your insurance.

I understand that payment is to be made at each session unless other arrangements have been made. Teletherapy sessions are billed at the same rate as office sessions. I also understand that I will be billed \$20.00 for checks returned for insufficient funds.

_____	_____	_____
Printed Client Name	Client/Legal Guardian Signature	Date
_____	_____	_____
Heather A. Astill, LCSW	Date	

Patient-Therapist Confidentiality and the Limits to Confidentiality

Patient confidentiality is a vital component of psychotherapy. It is extremely important that patients feel secure that what they discuss in therapy will not be shared. There are three circumstances in which a therapist is required to report confidential information to state public welfare officials:

1. Child abuse
2. Physical abuse of an elder or dependent adult living in the home
3. Expressed intent to harm oneself or another person

I have read, understand and agree to the terms stated herein.

_____	_____	_____
Printed Client Name	Client/Legal Guardian Signature	Date
_____	_____	_____
Heather A. Astill, LCSW	Date	