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? _____ Venmo Username:_____
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:

__ Asthma
__ Brain Injury
__ Digestive Disorders
__ Breathing Problems
__ High Blood Pressure
__ Arthritis
__ Thyroid Disorder
__ Pregnancy/Miscarriage
__ Serious Accident
__ Allergies
__ Epilepsy
__ Cancer
__ Diabetes
__ Multiple Sclerosis
__ Surgery
__ Headaches
__ Sexually Transmitted Disease
__ Sleep Disorder
__ Chronic Fatigue Syndrome
__ Heart Disease
__ Seizures
__ Sleep Disorder
__ Hearing Problems
__ 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 many hours of sleep do you average each night?_____ How many do you need to feel refreshed?___
Are there ever periods where you need much less sleep that usual?_____ If so, how much at that time?____
How often do you exercise?_____What do you do for exercise?_____

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:					

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

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, LSCSW, 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, LSCSW	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, LSCSW	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, LSCSW	Date