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: 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? 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.

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