CHILDREN'S INTAKE

PATIENT INFORMATION

Full Legal Name (First, Middle Initial, Last) :

_____

Address:

_____

City, State, Zip:

_____

Sex: Male _____ Female_____ Other _____ Date of Birth:_____

Social Security Number: _____

Email:

_____

_

Home Phone: _____ Cell Phone:

_____

Work Phone: _____ Referred by:

_____

Grade Level: _____ School:

_____

RESPONSIBLE PARTY/EMERGENCY CONTACT INFORMATION

Name: _____ Cell Phone:

_____

Address:

_____

City, State, Zip:

_____

Relationship:

_____

INSURANCE INFORMATION – (Complete information below with Policyholder information)

Full Legal Name (First, Middle Initial, Last) :

_____

Address:

_____

City, State, Zip:

_____

Sex: Male _____ Female_____ Other _____ Date of Birth:_____

Social Security Number: _____

Patient's Relationship to Policyholder (Spouse, child, etc.)

_____

Policyholder Employer:

_____

Is this covered under Employer's Employee Assistance Program (EAP)? Yes _____ No _____

EAP Contact Name: _____ Phone: _____

EAP Authorization Number;

_____

AUTHORIZED SIGNATURES:

I consent to the release of medical information other information necessary to process this claim; I also request payment of government benefits, either to myself of the party below.

_____

Signature Date

I authorize payment of medical benefits to the undersigned physician or supplier of services.

_____

Signature Date

****If there is a legal custody arrangement for the child, a copy of the agreement must be submitted BEFORE the child can be seen by Dr. Bauer.****

If a Custody Agreement exists, please explain the arrangement:

_____

_____

_____

_____

_____

PARENTS: Please complete this portion as thoroughly as possible

Primary Reason(s) for seeking services:

___ Anger management	____ Anxiety	____Coping	____Depression
___ Eating disorder	____ Fear/Phobias	____Mental confusion	____ Sexual concerns
___ Sleeping problems	___Addictive behavior	____Alcohol/Drugs	____ Hyperactivity

Other Mental Health concerns (specify):

_____

_____

_____

_____

_____

What are your goals for the child's therapy?

_____

_____
_____
_____
_____
What family involvement would you like to see in therapy?
_____
_____
_____
_____
_____
_____

Do you believe the child is suicidal at this time: _____ yes _____ no
If yes, please explain:
_____
_____
_____
_____
Have there been any other significant changes in the child's life, such as family death, moving, fire, etc?
_____ yes _____ no If yes, please explain:
_____
_____
_____
_____
_____

FAMILY HISTORY

Parents:
With whom does the child reside?
_____
_____
_____
_____
Are parents divorced or separated? _____ yes _____ no If yes, who has legal custody of the child?
_____
____
Were the child's parents ever married? _____ yes _____ no
Are both parents in agreement with counseling? _____yes _____ no
_____unknown

Child's Mother
Name: _____ Age: _____ Occupation:
_____
Employer: _____ Work Phone:
_____

Is there anything notable, unusual or stressful about the child's relationship with the mother?
_____ yes _____ no If yes, please explain:
_____
_____
_____
_____
_____

How is the child disciplined by the mother?
_____
_____
_____
_____
_____

For what reasons does the mother discipline the child?
_____
_____
_____
_____
_____

Child's Father

Name: _____ Age: _____ Occupation:
_____

Employer: _____ Work Phone:
_____

Is there anything notable, unusual or stressful about the child's relationship with the father?
_____ yes _____ no If yes, please explain:
_____
_____
_____
_____
_____

How is the child disciplined by the father?
_____
_____
_____
_____
_____

For what reasons does the father discipline the child?
_____
_____
_____
_____
_____

Step-Parent 1

Name: _____ Age: _____ Occupation: _____

Employer: _____ Work Phone: _____

Is there anything notable, unusual or stressful about the child's relationship with this step-parent?
_____ yes _____ no If yes, please explain:
_____
_____
_____
_____
_____

How is the child disciplined by the step-parent?
_____
_____
_____
_____
_____

For what reasons does the step-parent discipline the child?
_____
_____
_____
_____
_____

Step-Parent 2

Name: _____ Age: _____ Occupation: _____

Employer: _____ Work Phone: _____

Is there anything notable, unusual or stressful about the child's relationship with this step-parent?
_____ yes _____ no If yes, please explain:
_____
_____
_____
_____
_____

How is the child disciplined by the step-parent?
_____
_____
_____
_____
_____

For what reasons does the step-parent discipline the child?
_____
_____

_____

_____

_____

Client's siblings and others who live in the household

Name of Sibling	Age	Gender	Lives	Relationship with client:
_____ _____	___	___ F ___M ___Other	__home __away	__good __fair __poor
_____ _____	___	___ F ___M ___Other	__home __away	__good __fair __poor
_____ _____	___	___ F ___M ___Other	__home __away	__good __fair __poor
_____ _____	___	___ F ___M ___Other	__home __away	__good __fair __poor

Others living in the home:

Name	Age	Gender	Relationship (ex: cousin/ friend)	Relationship with client:
_____ _____	___	___ F ___M ___Other	_____ _	__good __fair __poor
_____ _____	___	___ F ___M ___Other	_____ _	__good __fair __poor
_____ _____	___	___ F ___M ___Other	_____ _	__good __fair __poor
_____ _____	___	___ F ___M ___Other	_____ _	__good __fair __poor

FAMILY MEDICAL HISTORY

Have any of the following diseases occurred among the child's blood relatives (parents, siblings, grandparents, aunts or uncles)? Check all that apply:

_____ Allergies	_____ Deafness	_____Muscular Dystrophy
_____ Anemia	_____ Diabetes	_____ Nervousness
_____ Asthma	_____ Glandular Problems	_____ Perceptual motor disorder
_____ Bleeding Tendency	_____ Heart Disease(s)	_____ Mental Impairment
_____ Blindness	_____ High Blood Pressure	_____ Seizures
_____ Cancer	_____ Kidney Disease	_____ Spina Bifida
_____Cerebral Palsy	_____ Mental Illness	_____ Suicide
_____ Cleft Lip	_____ Migraines	_____ Other (specify) _____
_____ Cleft Palate	_____ Multiple Sclerosis	_____ __

DEVELOPMENTAL HISTORY

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillbirths? _____ yes _____ no

If yes, please explain:

_____
_____
_____
_____
_____

Mother's age at birth _____ Father's age at birth _____

Child number _____ of _____ total children

While pregnant did the mother smoke? _____ yes _____ no If yes, how much _____

While pregnant did the mother use drugs or alcohol? _____ yes _____ no

If yes, how much _____

While pregnant did the mother have any medical or emotional difficulties (ex: surgery, hypertension, medication) _____ yes _____no If yes, please describe:

_____
_____
_____
_____
_____

Baby's birth weight? _____lbs _____oz Birth length: _____

Describe any physical or emotional complications during or after delivery:

_____
_____
_____
_____
_____

Infancy and Toddlerhood: Check all that apply:

_____Breast fed	_____ Milk allergy	_____ Vomiting	_____ Diarrhea
_____ Bottle fed	_____ Rashes	_____ Colic	_____ Constipation
_____Not cuddly	_____ Cried often	_____ Rarely cried	_____ Overactive
_____Resisted solid foods	_____ Trouble sleeping	_____ Irritable when awakened	_____Lethargic

Describe any notable delays or concerns regarding your child's physical, mental, emotional or social development:

_____
_____
_____
_____

Issues which affected the child's development (ex: physical/sexual abuse, inadequate nutrition, neglect):

_____
_____
_____
_____

EDUCATION

Current School: _____ School Phone: _____

Type of School: _____public _____ private _____ homeschool _____ Other (specify) _____

_____
_____
_____

Grade: _____GPA: _____ Teacher: _____ School Counselor _____

Is child in Special Education? ____ yes _____ no If yes, describe: _____

_____
_____
_____

Is child in Gifted Programs? _____ yes _____ no If yes, describe: _____

_____
_____
_____

Has child ever been held back in school? _____ yes _____ no If yes, describe: _____

_____
_____
_____

Has there been any recent change in the child's grades? _____ yes _____ no If yes, describe:

_____
_____
_____
_____

Has the child been psychologically tested? _____ yes _____ no If yes, describe: _____

_____
_____
_____
_____

Does the child have an Individualized Education Plan (IEP)? _____ yes _____ no If yes, describe: ____

_____
_____
_____
_____

Check the descriptions below which specifically relate to your child:

Feelings about School Work:

_____ Anxious	_____ Passive	_____ Enthusiastic	_____ Fearful
_____ Eager	_____ No expression	_____ Bored	_____ Rebellious
_____ Other (specify) _____			

Approach to School Work:

_____ Organized	_____ Industrious	_____ Responsible	_____ Interested
_____ Self-Directed	_____ No initiative	_____ Refuses	_____ Does only what
_____ Sloppy	_____ Disorganized	_____ Cooperative	is expected
			_____ Doesn't
			complete assignments
_____ Other (Specify) _____			

Performance in School (Parent's opinion):

_____ Satisfactory	_____ Underachiever	_____ Overachiever
_____ Other (Specify): _____		

Child's Peer Relationships:

_____ Spontaneous	_____ Follower	_____ Leader	_____ Difficulty
_____ Makes friends easily	_____ Long-time friends	_____ Shares easily	making friends
_____ Other (specify): _____			

Who handles responsibility for your child in the following areas:

School:	____ Mother	____ Father	____ Shared	Other: _____ _____
Health:	____ Mother	____ Father	____ Shared	Other: _____ _____
Problem Behavior:	____ Mother	____ Father	____ Shared	Other: _____ _____

LEISURE/RECREATION/AFTER-SCHOOL WORK

Describe special areas of interest, hobbies or after-school work the client has interest in (ex: art, books, crafts, sports, physical fitness, outdoor activities, church activities, school clubs, scouts, ect.)

ACTIVITY	HOW OFTEN NOW?	HOW OFTEN IN THE PAST?

Please describe any concerns you have with your child's activities:

List any current health issues:

List any recent health or physical changes:

Name of Primary Care Physician: _____ Phone: _____

List any medications your child is prescribed:

Name	Dose	Date Prescribed	Purpose	Side effects?

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List any over-the-counter medications your child takes:

Name	Dose	Date Prescribed	Purpose	Side effects?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

NUTRITION

Meal	How Often	Typical Foods Eaten	Typical Amount Eaten
Breakfast	___ x week	_____	_____
Lunch	___ x week	_____	_____
Dinner	___ x week	_____	_____
Snacks	___ x week	_____	_____
Comments: _____ _____ _____ _____ _____			

SUBSTANCE/CHEMICAL USE HISTORY

Does your child use or have a problem with alcohol and/or drugs? _____ yes _____ no
If yes, please explain:

_____
_____
_____
_____

COUNSELING/PRIOR TREATMENT HISTORY

Please complete this section with information about your child's past and present treatment history:

Type	Yes or No	If yes, when?	Reaction/Overall Experience?
Counseling/ Psychiatric Treatment	_____ __	_____ __	_____ __
Suicidal Thoughts/ Attempts	_____ __	_____ __	_____ __
Drug/Alcohol Treatment	_____ __	_____ __	_____ __
Hospitalizations	_____ __	_____ __	_____ __

BEHAVIORAL/EMOTIONAL

Please check any of the following that are typical for your child:

_____Affectionate	_____ Frustrated easily	_____ Sad
_____ Aggressive	_____ Gambling	_____ Selfish
_____ Alcohol problems	_____ Generous	_____ Separation anxiety
_____ Angry	_____ Hallucinations	_____ Sets fires
_____ Anxiety	_____ Head banging	_____ Sexual addiction
_____ Attachment to dolls	_____ Heart problems	_____ Sexual acting out
_____ Avoids adults	_____ Hopelessness	_____ Shares
_____ Bedwetting	_____ Hurts animals	_____Short attention span
_____ Blinking/Jerking	_____ Imaginary friends	_____ Shy/Timid
_____ Bizarre behavior	_____ Impulsive	_____ Sleeping problems
_____ Bullies/Threatens	_____ Irritable	_____ Slow moving
_____ Careless/Reckless	_____ Lazy	_____ Soiling
_____ Chest pains	_____ Learning problems	_____ Speech problems
_____ Clumsy	_____ Lies frequently	_____ Steals
_____ Confident	_____ Listens to reason	_____ Stomach aches
_____ Cooperative	_____ Loner	_____ Suicide threats
_____ Cyber addiction	_____ Low self-esteem	_____ Suicide attempts
_____ Defiant	_____ Messy	_____ Talks back
_____ Depression	_____ Moody	_____ Teeth grinding
_____ Destructive	_____ Nightmares	_____ Thumb sucking
_____ Difficulty speaking	_____ Obedient	_____ Tics or twitches
_____ Dizziness	_____ Often sick	_____ Unsafe behaviors
_____ Drug dependence	_____ Oppositional	_____ Unusual Thinking
_____ Eating disorder	_____ Overactive	_____ Weight Loss
_____ Enthusiastic	_____ Overweight	_____ Withdrawn

_____ Excessive masturbation	_____ Panic attacks	_____ Worries excessively
_____ Expects failure	_____ Phobias	Other: _____
_____ Fatigue	_____ Poor appetite	_____
_____ Fearful	_____ Psychiatric problems	_____
_____ Frequent Injuries	_____ Quarrels	_____

How are problem behaviors generally handled in the home?
_____
_____
_____
_____
_____

What are the family's favorite activities?
_____
_____
_____
_____
_____

What does the child do with unstructured time?
_____
_____
_____
_____
_____

Any additional information you believe would assist in understanding your child?
_____
_____
_____
_____
_____

Any additional information that would assist in understanding the current concerns or problems?
_____
_____
_____
_____
_____

APPOINTMENT REMINDERS AND ONLINE SCHEDULING

You can receive an appointment reminder by email, text message or phone call a day before your scheduled appointment. You can also schedule online at any time. Once your account is established you simply visit www.therapyappointment.com. If you want to utilize this service, please complete the following:

Requested Login Name:

_____

Requested Password:

_____

Your Email Address: _____ @

_____

Your Cell Phone Number:

_____

Your Home Phone Number:

_____

Where would you like to receive appointment reminders (check one)

_____ via standard text message
_____ via email
_____ via automated phone call to my cell phone number
_____ via automated phone call to my home phone number
_____ None of the above; I'll remember my appointments on my own (missed appointment fees will apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By signature below I'm waiving my right to keep this information completely private, and requesting that it be handled as I have noted above

_____

_____

Signature Date

*****PLEASE RECORD YOUR LOGIN AND PASSWORD INFORMATION FOR YOUR RECORDS*****