Mindsight

Integrative Therapy Services

Child/Adolescent Client Intake Paperwork

Client Name:

_____Date_____/_____/_____

Date of Birth: _____ Age: _____ Social Security Number: _____

Parent(s) or Guardian's name(s):

_____DOB_____

_____DOB_____

Who does the child live with or what are the custody arrangements if necessary?

_____

_____

Child's Address: (of each parent if necessary)

_____

_____

Phone Number: Home/Cell of each parent

_____

_____

Email address:

_____

Is it ok to contact you at this email address or phone number? _____ Yes _____ No

Please briefly describe your presenting concern(s)

_____

_____

_____

_____

_____

Parental Relationship Status: Married, divorced, separated, etc.

Relationship Status: _____

How would you describe your relationship: (check all that apply) Fulfilling Adequate Neutral Unsatisfying Distant Chaotic Abusive

Do you have other children? Names and ages:

_____

_____

Parent's Employment Status:

Parent name: _____

Unemployed Part-Time Full-Time Per-diem Disability Retired

Place of employment: _____

Parent name: _____

Unemployed Part-Time Full-Time Per-diem Disability Retired

Place of employment: _____

Family History:

Describe your relationship with your child:

_____

_____

_____

_____

Family History: (Click all that apply)

Drug/Alcohol use	**Physical Abuse**	**Depression**
Legal trouble	**Sexual Abuse**	**Anxiety**
Domestic Violence	**Hyperactivity**	**Psychiatric Hospitalization**
Suicide	**Learning Disabilities**	**Nervous Breakdown**

Medical/Psychiatric History

Current Medications:

_____

_____

_____

_____

Has your child ever been in therapy before? _____ Yes _____ No

If so, with who and for how long?

_____

What is your child struggling with or concerned about? Please check all that apply:

Anxiety
Depression
Mood swings
Intrusive thoughts
Obsessions
Fears
Irritation
Hyperactivity
Drugs
Alcohol
Attention and concentration
Memory
Thoughts of self-harm
Panic attacks
Relationships
Marriage/partner
Employment
Finances
Nightmares
Domestic violence
Abuse
Sexual abuse
Child abuse
Parenting
Body image
Disorganized eating
Impulse control

Have you, anyone in your family, or your child ever been hospitalized for psychiatric reasons?

_____

_____

_____

To your knowledge have you, anyone in your family, or your child ever received a psychiatric diagnosis and if so, what was it?

_____

_____

_____

Tell us a little bit about why you're seeking services, if there have been any recent changes in your life, or things you would like to work on.

_____

_____

_____

_____

Emergency Contact information: Names and numbers and relationship to you.

_____

_____

<u>Billing information</u>:

Do you have insurance? _____ Yes _____ No

Insurance Carrier: _____

Policy Number_____

Policy holders name, date of birth, and social security number (if not you)

_____

_____

_____

Our practice uses Lily, a payment platform that requires that we send a link to your phone for payment. You can use this link to input your debit/credit card or bank information. Which number should we use to send the link to?

_____

Our practice uses electronic communication for appointment reminders and other communication. What is the best phone number to text and email address to use to get in touch with you?

_____

_____