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CHILD INTAKE FORM

Child Name: _____ **Gender:** M F **Date of Birth:** _____

Home Address: _____ **City/State/Zip:** _____

Mother's Name: _____ **Father's Name:** _____

Mother's Occupation & Employer: _____ **Father's Occupation & Employer:** _____

Parents Are: married divorced separated unmarried **Stepparents' Names:** _____

Phone Contacts: Please indicate whose numbers each of these belongs to (e.g., mother, father, etc.) & the best times to reach you:

Home: _____ **Work:** _____

Cell: _____ **Other:** _____

Email Address: _____ **Do I have permission to correspond with you via email?** Yes No

INSURANCE INFORMATION

PRIMARY INSURANCE
Insured's Name: _____
(Last, First, MI)

DOB: _____

Relationship to Patient: _____

Employer: _____

Employer's Address: _____

Insurance Company: _____

ID#: _____

Group #: _____

Plan Name: _____

Phone: _____

SECONDARY INSURANCE
Insured's Name: _____
(Last, First, MI)

DOB: _____

Relationship to Patient: _____

Employer: _____

Employer's Address: _____

Insurance Company: _____

ID#: _____

Group #: _____

Plan Name: _____

Phone: _____

Who Referred You?: _____

1802 Black Lake Blvd SW, Suite 103, Olympia, WA 98512 T: 360.402.6117 F: 360.512.3656 E: karameyerphd@gmail.com

FINANCIAL AGREEMENT

(To be completed and signed by individual responsible for payment)

Patient name: _____

I _____agree to pay all fees and charges for evaluation and treatment for the person named above.

I agree to pay all charges promptly unless credit arrangements are agreed upon in advance. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date.

NOTICE: You are entitled to a copy of this agreement.

Signature: _____ Date: _____

Person Responsible for Payment

Bill to address: _____

Message Phone Number: _____

DEVELOPMENTAL HISTORY:

Child's birth weight: _____ **Was the child born early? If so, how early?** _____

Was the child born via c-section? If yes, was it planned or emergency?

_____

Were there any complications during pregnancy, delivery, or following birth? Please describe:

_____

_____

Biological mother's age at time of birth? _____ **Biological father's age at time of birth?** _____

In your child's first 4 years:

Were there any feeding/eating problems? Yes No **Was he/she difficult to sooth?** Yes No

Was he/she colic? Yes No **Were there any problems with sleep?** Yes No

Were there any problems with separating from parents? Yes No **Were there any motor problems?** Yes No

What was his/her activity level? Low Average Very Active **How sociable was he/she?** Not very Average Very Sociable

At what age did your child reach his/her developmental milestones?

Sitting up: _____ **Crawl:** _____ **Walk:** _____ **Speak:** _____

Toilet Train? _____

Please describe the above or any other concerns you have about your child's development:

_____

_____

MEDICAL HISTORY:

Who is your child's pediatrician? _____ **Current Medications:** _____

Does your child have a history of chronic illness (e.g., diabetes, asthma, cancer, etc.)? If so, please provide a brief history:

_____

_____

_____

Has your child had any surgeries or hospitalizations? If so, please describe:

_____

_____

_____

Does your child experience any of the following? Please circle all that apply and describe in the space below:

Headaches Stomachaches Urine accidents Bowl Accidents Constipation Problems with weight Allergies Other

_____

_____

_____

Does your child experience any problems with sleep (e.g., difficulty falling or staying asleep, nightmares, night terrors, behavior problems at bedtime)? Please describe:

_____

_____

_____

Do you have any other concerns about your child's health?

SCHOOL HISTORY:

Child's Current School: _____ **Grade:** _____ **Teacher:** _____

Does your child experience problems in any of the following areas? Please circle all that apply and describe in the space below:

Reading Math Spelling Writing Poor Work Completion Poor Grades

_____

_____

_____

Does your child receive any special education services, have an IEP, or 504 Plan, etc. If so, please describe:

_____

_____

_____

Does your child have a history of behavior problems in school, suspensions, or expulsions? If so, please describe:

_____

_____

_____

Describe current performance:

_____

_____

_____

SOCIAL HISTORY:

Does your child have difficulty making friends? YES NO
Describe: _____

_____

Does your child prefer to play alone? YES NO
Describe: _____

_____

Does your child have frequent fights or is s/he aggressive with peers? YES NO
Describe: _____

_____

Does your child have problems relating with other children? YES NO
Describe: _____

_____

Do you have any other concerns about your child's social development? YES NO
Describe: _____

_____

What are your child's interests and hobbies? YES NO
Describe: _____

_____

Does your child participate in sports or other community activities? YES NO
Describe: _____

_____

BEHAVIORAL HISTORY:

Does your child frequently refuse to do what s/he is told? YES NO
Describe: _____

_____

Does your child seem impulsive? YES NO
Describe: _____

_____

Does your child seem to lack self-control? YES NO
Describe: _____

_____

Does your child withhold affection or hide feelings? YES NO
Describe: _____

_____

Does your child seem unhappy? YES NO
Describe: _____

_____

Is your child fearful? YES NO
Describe: _____

_____

Is your child easily frustrated? YES NO
Describe: _____

_____

Does your child have difficulty calming down once upset? YES NO
Describe: _____

_____

FAMILY HISTORY:

Family Members Living in the Home:		
NAME	**RELATIONSHIP**	**AGE**

Parents Are: Married Separated Divorced Never Married (please circle one)

If divorced or separated, please note date of separation/divorce: _____

Parents' relationship is: _____

Have there been any recent stressors for the family? If yes, please describe:

_____
_____
_____

Is there a family history of mental health concerns (e.g., depression, anxiety, autism, suicide, etc.)?

_____
_____
_____

Has your child ever seen a counselor, psychologist, psychiatrist, or other mental health professional before? If so, please describe with whom, when, and why:

_____
_____
_____

What are your child's strengths?

_____
_____
_____

Please provide a brief description of why you are seeking services at this time:

Thank you for taking the time to complete this form!