ENHANCE LIFE COUNSELING, LLC

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Child/Youth Intake Form

Name: _____
First Name Middle Initial Last Name

DOB: _____ Age: _____

Address: _____ Apt# _____

City, State, Zip: _____

Phone Numbers: _____ _____ _____
Home Cell Work

Email Address: _____

Please list all persons (including yourself) currently living in your household.

	Name:	Relationship	DOB	Age	Occupation/Years of Education
1					
2					
3					
4					
5					

Describe your family, culture and religious connections: _____

_____

_____

Who referred you to us: _____

What problems bring you to seek treatment: _____

Is treatment Court Ordered: _____ _____
Yes No

Who is legally authorized to receive information about and make decisions regarding this child's care?

_____
Name Relationship Phone Number

_____
Name Relationship Phone Number

Social: Play and Recreation: describe your child's play and recreation interests

_____

_____

Last Grade Level Achieved: _____

Spirituality:

Would you describe your spiritual beliefs as producing: _____ Comfort _____ Stress _____ N/A

Are you an active participant in a religious community? _____ Yes _____ No _____ N/A

Would you like the counseling process to include:

Scripture Discussion: _____ Yes _____ No Prayer: _____ Yes _____ No

Developmental History:

Pregnancy: _____ Full Term _____ Premature _____ Late Delivery: _____ Normal Delivery _____ C-Section

Problems during pregnancy: _____

Milestones: _____ months Walking _____ months Talking _____ months Toilet Trained

Parenting Time Arrangements:

if applicable please provide a copy of any current court orders regarding the parenting time plan. _____ Yes _____ No

Self/Family Mental Health History:

(Please mark each that apply with '1' for self, '2'for immediate family '3' for extended family)

_____ Individual Therapy
_____ Marital Therapy
_____ Family Therapy
_____ Sex Therapy
_____ Domestic Violence
_____ Anger Management
_____ Group Therapy
_____ Grief
_____ Loss
_____ Anxiety
_____ Depression
_____ ADHD
_____ Sexual Abuse
_____ Physical Abuse
_____ Bipolar Disorder
_____ Eating Disorder
_____ Psychiatric Hospitalizations
_____ Schizophrenia
_____ Antisocial Behavior (history of violating the law)
_____ Drug Use
_____ Other Substances
_____ Alcohol Use
_____ Other Addictions

Self/Family Medical Health History:

(Please mark each that apply with '1' for self, '2'for immediate family '3' for extended family)

_____ Asthma
_____ High Blood Pressure
_____ Kidney Disease
_____ Dental Problems
_____ Cancer
_____ Thyroid Problems
_____ Liver Disease
_____ Tuberculosis
_____ Diabetes
_____ Seasonal Allergies
_____ Heart Disease
_____ Head Injury
_____ Hearing Issues
_____ Seizures
_____ Allergies
_____ Other

Currently Prescribed Medications and Prescribing Physician:

_____

_____

Current General Functioning: (Please mark each that apply)

_____ Cheerful/Happy mood most of the time

_____ Withdrawn behaviors/Isolation

_____ Decrease in interests/activities

_____ Weight Loss

_____ Suicidal Thoughts

_____ Poor self-care/poor hygiene

_____ Worry

_____ Stress

_____ Takes more than an hour to fall asleep

_____ Unable to sleep in own bed through the night

_____ Fearless/Engaging in reckless activities

_____ Threat to hurt someone with intent/plan

_____ Stealing

_____ Verbal threats to harm others

_____ Explosive outbursts

_____ Legal Problems

_____ Problems with school performance

_____ Inability to sustain attention

_____ Impulsivity

_____ Nightmares

_____ Sexual concerns

_____ Problems with relationships

_____ Divorce

_____ Martial Problems

_____ Shame

_____ Concerns with child care

_____ Intentional purging

_____ Binge eating

_____ Sad or tearful most of the time

_____ Difficulty concentrating

_____ Feelings of guilt

_____ Increased appetite

_____ No Energy

_____ Suicide attempts

_____ Poor memory

_____ Panic

_____ Irritability

_____ Night waking for longer than 30 minutes

_____ Fearful of places, situations or people

_____ Exaggerated views of abilities

_____ Physical aggression

_____ Physical cruelty to animals

_____ Thoughts of harm to others

_____ Distinct periods of nonstop activity

_____ Extreme conflict with others

_____ Problems with work performance

_____ Easily distracted

_____ Compulsions

_____ Sleepwalking

_____ Excessive masturbation

_____ Jealousy

_____ Marital Affair

_____ Trust

_____ Crisis

_____ Disability

_____ Anorexia

_____ Body image

_____ Obesity

_____ Feelings of hopelessness/ emptiness

_____ Under active/sluggish behavior

_____ Down most days

_____ Weight gain

_____ Overly fatigued during the day

_____ Intentional self-harm (i.e. cutting)

_____ Extreme ups and downs in moods

_____ Avoidant

_____ Anger

_____ Hard to wake up in the morning

_____ Fast/Rapid speech feel rested after 3-4 hours of sleep

_____ Lying

_____ Conflict with authority Figures

_____ Property damage

_____ Inability to remain seated

_____ Poor social skills

_____ Grandiosity-unrealistic sense of superiority

_____ Inability to complete tasks

_____ Overactive/hyperactive

_____ Denial

_____ Wetting accidents

_____ Pain during intercourse

_____ Blended family

_____ Family conflict

_____ Enabling

_____ Concerns with elder care

_____ Employment

_____ Hoarding Food

_____ Bulimia

_____ Self-esteem

Authorization and Consent to Treat a Minor

By signing below you are authorizing Enhanced Life Counseling to provide your child with mental health services. I acknowledge that both natural parents even though divorced may have a right to obtain from Enhanced Life Counseling information regarding the nature and course of treatment of the child named above. If you are a divorced parent, stepparent, grandparent, guardian or other, you are required to provide a copy of the court order which names you legal custodian of the above named child. (MUST BE SIGNED BEFORE SERVICES CAN BE PROVIDED)

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Child/Youth Signature _____ Date _____

Billing Information: If billing information is not complete and accurate, we reserve the right to NOT schedule additional appointments until it is supplied.

Payment Options: _____ Insurance _____ Self-pay _____ Other

Primary Insurance Policy Information: _____

Primary Insurance Company: _____ Insurance Group Number: _____

Insurance Member ID Number: _____

Effective Date:

Primary Insurance Insured Person Information: _____

Client's relationship to insured (i.e. self, spouse, child, other) _____

Insured Name: _____

Insured's Street Address: _____

Insured's City, State, Zip: _____

Insured's Phone Number: _____ Insured's Gender _____ Male Female

Insured's Date of Birth: _____

Insured's Employer: _____

By signing this agreement below you agree to and acknowledge each of the following conditions:

1. The information provided regarding insurance coverage is accurate.
2. Payment for any and all required co-payments, deductibles, coinsurance and non-allowable charges is required and due at the time the service is delivered. Payment must be in the form of cash, check or credit card.
3. If your insurance company denies, refuses, or fails to make payments for the services rendered, Enhanced Life Counseling, LLC will notify you in writing.
4. You assume responsibility for any and all fee's rendered associated with services including documents preparation fees provided at Enhanced Life Counseling.
5. You will be solely responsible for the full cost of the session if you do not show up for your appointment or do not cancel at least 24 hours in advance.
6. Insufficient fund checks will be assessed a $30 charge.
7. You are responsible for notifying Enhanced Life Counseling, LLC of any changes in name, address, phone number or insurance coverage.
8. By signing this agreement, you agree to allow Enhanced Life Counseling, LLC to release any and all information necessary for tiling insurance claims and collecting fees from your insurance company.
9. Enhanced Life Counseling, LLC shall have the authority to charge and assess collection costs and expenses, including reasonable attorney's fees, and penalties and interest for the late payment or nonpayment thereof.

Print Name: _____

Signature X: _____ Date: _____