Dr. Jackie Jiang & Associates
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Minor Intake Form

Referred by: _____ (Person and/or Agency)
Minor's Name: _____ (First, Middle Initial, & Last)
Home Address: _____ City, State, & Zip: _____
Date of Birth: _____ Ethnicity: _____

Name of legal guardian: _____ Relationship: _____
Home Address (if different): _____
Legal guardian Social Security Number (SSN): _____
Place of Employment: _____ Job Title: _____
Cell Phone # _____ Email: _____
Preferred Contact Method: ☐ Email ☐ Phone ☐ Text message

Has the client being seen today been a patient here before? (Please circle) Yes No

The purpose for this evaluation (check all that apply):
□ Educational, e.g., IEP/504 plan
□ Medication management
□ Self-aware/self-improvement
□ Career choice
□ Legal/forensic, please specify: _____
□ Other, please specify_____

What diagnoses are you speculating or wanting to confirm (check all that apply):
□ Autism □ ADHD □ Learning disabilities □ Developmental delays □ Behavioral disorders
□ Depression □ Bipolar □Anxiety □ OCD □ PTSD □ Personality Disorders □ Giftedness
□ Other, please specify: _____

When did the problem start? _____
How long has this problem been going on? _____
How often does the problem occur? _____
How does the problem affect the minor's daily life/functioning? _____
_____
_____
What steps have you taken so far to resolve this problem? What have been the results of your attempts to resolve this issue? _____
_____
_____
_____

Minor's Family History:

Born in: _____ (city & state); Currently living in: _____ (city& state) in a (please circle): house, apartment, trailer, duplex, shelter, homeless, other_____ (please specify). Who the minor is currently living with: _____
Parents have been married for _____years; or parents were divorced when the minor was _____years old. How many Siblings____ /half-siblings____ /step-siblings____ and their age(s)_____

On **mom's** side of the family has the following diagnoses or difficulties (please circle): depression, anxiety, bipolar, schizophrenia, ADHD, learning disorders, autism, substance abuse, alcoholism, criminal conduct, domestic violence, and abuse.
On **dad's** side of the family has the following diagnoses or difficulties (please circle): depression, anxiety, bipolar, schizophrenia, ADHD, learning disorders, autism, substance abuse, alcoholism, criminal conduct, domestic violence, and abuse.

Minor's Developmental History:

Has the minor met the developmental milestones early, normal, or delayed?

	early	normal	delayed
Walking	_____	_____	_____
Talking	_____	_____	_____
Potty Training	_____	_____	_____

Has the minor ever received speech therapy? Yes____ No_____ If "yes", please indicated the time frame _____

Has the minor ever abused or neglected as a child? Yes ___ No ___
If "Yes", please specify from age (or year) _____ to age (year)_____ and Type of abuse: Verbal, physical, sexual, emotional (circle) by _____ (stranger, family friend, neighbor, family member, etc.)
Was there a DCFS/DHS involvement? Yes ___ No ___ If yes, was the case founded? Yes ___ No ___

Medical, Mental, Behavioral, and Physical Diagnoses:

Diagnoses received	When (month/year)	Which agency/organization	Professional (Primary care, Psychiatrist, Counselor, etc.)

Psychiatric Hospitalization:

When (month/year):_____ Which Hospital: _____ How long the say: _____
Reason for hospitalization: □ suicidal thoughts □ suicidal attempt □overdose on_____
□ homicidal ideation □ psychosis, please explain: _____
_____
_____
When (month/year):_____ Which Hospital: _____ How long the say: _____
Reason for hospitalization: □ suicidal thoughts □ suicidal attempt □overdose on_____
□ homicidal ideation □ psychosis, please explain: _____
_____
_____

History of Counseling/Therapy (if applicable):

From _____ to _____ (year or age), received counseling for _____
From _____ to _____ (year or age), received counseling for _____
From _____ to _____ (year or age), received counseling for _____

History of Occupational Therapy and Physical Therapy (if applicable):

From ____(weeks/months) in _____ (year or age), received _____ (OT/PT) for _____
From ____(weeks/months) in _____ (year or age), received _____ (OT/PT) for _____

Medication(s):

Medicine Name	Dosage (mg)	When initially prescribed	Continue or Discontinued?
			C D
			C D
			C D
			C D

Drug & Alcohol History:

Drug/alcohol Name	1st time use age	Frequency	Last time use date or age	How much (last time use)

Educational History:

Name of the most current school (e.g., elementary, middle, high school) _____

City & State: _____ Grade: _____ GED (if applicable) _____
If college, Degree:_____; Major: _____;
Current GPA/grades: _____

Any classes are/were in the IEP program (Special Ed)? Yes ____ No____
If "yes", what is/was the time frame for the IEP? From _____th grade to _____th grade? which classes involved? _____
Any classes are/were in the 504 program? Yes ____ No____
If "yes", what is/was the time frame for the 504 plan? From _____th grade to _____th grade? which classes involved? _____

Does/did the minor struggle with the following when you were in school:

- peer relationship difficulties ___
- authority problems_____
- academic problems _____

Please explain if any of the above was checked: _____
_____

Employment History

Is the minor currently employed? Yes _____ No_____

Most recent/current employment _____ Position/title: _____
Full-time or part-time? _____How long has the minor worked here? _____
Work-Related Difficulties, if any: _____
_____
Reasons for quitting/termination: _____
_____

Previous employment _____ Position/title: _____
Full-time or part-time? _____How long has the minor worked here? _____
Work-Related Difficulties, if any: _____
_____
Reasons for quitting/termination: _____
_____

Legal/Criminal History

Please list the year(s) and charges(s) the minor received in his/her life, if any.

Year Charges Jail Term and/or fines?

_____ _____ _____
_____ _____ _____
_____ _____ _____

Religious Involvement

Religious belief: _____ Going to church? ☐ Yes ☐ No

If "Yes", how often? _____

Hobbies & Activities

Please list a few things the minor does for fun (such as bike riding, building Legos, etc.):

_____

_____

_____

Financial Responsibility

The responsible party for payment will be (please circle):

Client self Mother Father Other (please specify): _____

Responsible party contact information (if different from above):

Name: _____ (First, Middle Initial, & Last)

Home Address: _____

Date of Birth: _____ SSN: _____

Cell Phone # _____ Home Phone: _____

Place of Employment_____ Job Title _____

Employment Address: _____

Work Phone # _____

Insurance(s) Information

[*<u>You may *skip* this section</u> if you submitted a copy of your insurance card(s). Please sign at bottom.]

Primary Insurance Company:_____

Employer_____

Policy Holder Name: _____SSN:_____DOB: _____

Address: _____

Group ID Number: _____Group Number: _____

Policy Number: _____

Pre-Authorization Number _____ Number of Sessions: _____

Secondary Insurance Company:_____
Employer_____
Policy Holder Name: _____SSN:_____DOB: _____
Address: _____
Group ID Number: _____Group Number: _____
Policy Number: _____

☐ I hereby authorize my insurance company to make payment directly **to <u>Dr. Jackie Jiang & Associates, LLC</u>** for professional services rendered and I shall be personally responsible for any unpaid balance to the clinician.

☐ I do **not** wish my insurance to be billed and I will pay for services rendered. I understand that a service charge of 1.5% (18% per year) may be added to any outstanding co-pay or deductible balance more than 30 days old.

Signature of minor (Age 12-17): _____ Date: _____

Signature of legal guardian: _____ Date: _____