**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 #

Preferred Contact Method:  Email  Phone  Text message

Has the client being seen today been a patient here before? 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: Choose an item.

(please specify if live in “other”:      )

Who are currently living with you (how they relate to you):

How many Siblings      /half-siblings      /step-siblings      and their age(s)

On **mom’s** side of the family has the following confirmed diagnoses or problems: 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 confirmed diagnoses or problems: 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?

Walking Choose an item. Talking : Choose an item. Potty Training: Choose an item.

Has the minor ever received speech therapy? Yes No If “yes”, please indicated the time frame (which grade/year to which grade/year):

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: Choose an item. By stranger(s), family friend, neighbor, family member. If family member, how does the family member relate to you?

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 |
|  |  |  | Choose an item. |
|  |  |  | Choose an item. |
|  |  |  | Choose an item. |
|  |  |  | Choose an item. |

**Psychiatric Hospitalization:**

When (month/year):       Which Hospital:       Length of stay:

Reason for hospitalization: suicidal thoughts suicidal attempt overdose on       homicidal ideation psychosis, please explain:

When (month/year):       Which Hospital:       How long the say:

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**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):**

      (year or age), for how long       received Choose an item. for

      (year or age), for how long       received Choose an item. for

**Medication(s):**

|  |  |  |  |
| --- | --- | --- | --- |
| Medicine Name | Dosage (mg) | When initially prescribed (month/year) | Continue or Discontinued? |
|  |  |  | Choose an item. |
|  |  |  | Choose an item. |
|  |  |  | Choose an item. |
|  |  |  | Choose an item. |
|  |  |  | Choose an item. |
|  |  |  | Choose an item. |

**Drug & Alcohol History:**

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

**Educational History:**

Highest level of education (e.g., elementary, middle, high school, or college)

City & State:       GED (if applicable): Choose an item.

If college, Degree: Choose an item.; Major:       GPA upon graduation:

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**

Are you currently employed? Yes No

Most recent/current employment place:       Position/title:

Full-time or part-time? How long have you worked here?

Work-Related Difficulties, if any:

Reasons for quitting/termination:

**Legal/Criminal History**

Please list the year(s) and charges(s) you received in your life, if you have any.

Year Charges Jail Term and/or fines?

Are you currently on probation? Yes No If “yes”, when will your probation end?

**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: Client self Mother Father Other (please specify):

Responsible party contact information (if different from client self):

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**

**[\*You may *skip* this section if you submitted a copy of your insurance card(s).**

**Please sign at bottom.]**

Primary Insurance Company:

Employer:

Policy Holder Name:       SSN:       DOB:

Address:

Policy ID Number:       Group Number:

Secondary Insurance Company:

Employer:

Policy Holder Name:       SSN:       DOB:

Address:

Policy ID Number:       Group Number:

I hereby authorize my insurance company to make payment directly **to Dr. Jackie Jiang & Associates, LLC for** professional services rendered and I shall be personally responsible for any unpaid balance to the group practice. I agree that my electronic signature is the legal equivalent of my manual/handwritten signature on this document.

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.

Client Signature:       Date: