Main Street Counseling and Play Therapy, LLC

CHILD/ADOLESCENT INTAKE FORM

Child's Legal Name: ___________________________________ Nickname: ___________________________

Child's Address: ___________________________________City_____________State ________Zip__________

Child's D.O.B ____/_____/___________ Age: ______ Gender: ______

Child's Primary MD: ______________________________ Who referred you: ___________________________

FAMILY INFORMATION

Parent 1: ____ Biological Adoptive Step

Address: ________________________________ City: _________________ State: ________ Zip: __________

Cell Phone: ___________________________ Other Phone: _________________________ Work Home

Email address: ____

Place of Employment: __________________________________ Occupation: __________________________

Parent 2: ____ Biological Adoptive Step

Address: ________________________________ City: _________________ State: ________ Zip: __________

Cell Phone: ___________________________ Other Phone: _________________________ Work Home

Email address: ____

Place of Employment: __________________________________ Occupation: __________________________

STATUS OF PARENTS: Married __/__/__ Separated__/__/__ Divorced__/__/__ Unmarried

Other (Specify): ____

If separated or divorced, visitation schedule: ____

____

Other Caregiver's Name: _________________________________ Relation to Child: ____________________

Address: ________________________________ City: _________________ State: ________ Zip: __________

Cell Phone: ___________________________ Other Phone: _________________________ Work Home

Email address: ____

Place of Employment: __________________________________ Occupation: _______________________

Others living at home:

Siblings (Oldest to Youngest): _____________________ Relation __________

______________________ Age: _____ _____________________ Relation __________

______________________ Age: _____ _____________________ Relation __________

______________________ Age: _____ _____________________ Relation __________

Does either parent have legal issues/concerns? ____

Custodial Agreement? ____

Has child witnessed parental arguments? ___ Yes ___No Specify: ____________________________________

Has child witnessed domestic violence? ___Yes ___No Specify: ____________________________________

DISCIPLINE PHILOSPOHY

Who usually disciplines your child? ____

Do the adults caring for the child agree on discipline? __________________________________

How is your child disciplined? (check all that apply)

Spank   Take away privileges   Yell   Send to room   Talk to/Reason with   Time out   Extra Chores

OTHER: ____

How often:

Do you reward your child for obeying or behaving well?	Often	Sometimes	Never
Do you ignore your child when he/she is misbehaving?	Often	Sometimes	Never
Does your child talk you out of being punished?	Often	Sometimes	Never
Do you let your child out of punishments?	Often	Sometimes	Never

(e.g., lifting restrictions earlier than you originally said)

MENTAL HEALTH HISTORY

Previous Mental/Behavioral Health Providers:

Name: ___________________________ Dates: __________Issues or Diagnosis: __________________________

Name: ___________________________ Dates: __________Issues or Diagnosis: __________________________

Any Suicidal verbalizations ___ Yes ___No Specify: _____________________________________

Suicide attempts ___ Yes ___No Specify: _____________________________________

Hospitalizations: ___ Yes ___No Specify: _____________________________________

List any history or suspicion of mental illness or addiction in immediate or extended family
(E.g. depression, anxiety, suicide attempts/completions, ADHD, alcoholism, drug abuse, etc.):

____

____

ACADEMIC PERFORMANCE

Child's School: _____________________________ Teacher/Counselor: __________________ Grade: ______

Has child been received or participated in any of the following services:

Learning disabilities

Resource room

Emotional/behavioral disorders

Speech/language therapy/Occupational Therapy

Autism services

Individualized Education Plan (IEP)

504 plan

Gifted/High ability programs

Social skills group

Other: __________________________________

How does your child do academically in school? ____

Any suspensions, expulsions, or other behavioral issues: _____________________________________

Child's strengths in school/subjects: ____

Child's weaknesses in school/subjects: ____

DEVELOPMENTAL HISTORY

Any health problems in mother during pregnancy or post-partum including depression or anxiety:

____

Delivery was: Vaginal Caesarean List any complication during labor and delivery:

____

Baby was: Full-term Premature, by how many weeks? ___________________________________

Please check if there were any problems during infancy or toddler years with:

Feeding problems	Poor eye contact	Not Active
Colic	Overly shy	Liked to play alone
Delayed responses	Very outgoing	Repetitive play
Hearing	Overly compliant	Loud
Difficult to soothe	Very insistent	
Didn't like to be held	Overactive	

Please check if there were any delays with:

Rolling over	Walking	Toilet Training
Sitting up unassisted	Fine motor skills	Speech/ Language
Crawling	Gross motor skills	

Did your child experience?

Abuse Neglect Parental Stress Chronic Pain Separation from Mother

Prenatal exposure to substances Out of Home Care Disruption in Bonding Depression of Mother

____

____

MEDICAL HISTORY

How would you describe your child's health? Very Good Good Fair Poor Very Poor

Has your child had any other medical problems, illness, injuries, surgeries, or hospitalizations?
Yes No If yes, specify: ____

Does your child have bladder or bowel control problems? Yes No If yes, explain

____

Typical Bedtime: ___________________________ Typical Wake time: _______Wk Days _______Wk Ends

Describe child's sleep patterns and habits:

Sleeps all night without disturbance	Watches TV/plays video games up to bedtime
Difficulty falling asleep	Sleeps outside of bedroom
TV in bedroom	Gets up after bedtime to watch TV/play games
Awakens during the night/restless	Sleepwalking
Early morning awakening	

Describe this child's appetite:
Overeats Average Under eats Binges Purges Other Concerns: ____________________________

Is your child taking any medications, including over the counter and vitamins?

Name:	Dose:	Frequency:
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Past medications tried and reasons stopped: ____

____

TRAUMA HISTORY

Has your child ever been verbally, physically, or sexually abused? Yes No Suspected

Specify: ____

Other stressors or traumas (e.g. death of love one, car accident, medical procedure, tornado, earthquake):

____

____

BEHAVIOR SYMPTOMS

Check any issues your child has:

- Anger
- Anxiety
- Acts Out Sexually
- Conduct Problems
- Controlling
- Defiance
- Depression
- Homicidal Thoughts/Action
- Dissociates
- Hyperactivity/Impulsivity
- Hypervigilance
- Impaired Conscience
- Lack of Empathy
- Legal Problems
- Lack of Motivation
- Plays Out Violent Themes
- Low Self-Esteem
- Lying
- Nightmares
- Night Terrors
- Obsesses
- Suicidal Thoughts/Actions
- Self-Harm/ Cutting
- Peer Problems
- Phobias
- Running Away
- Shy
- Startles Easily
- Stealing
- Tantrums

SOCIAL BEHAVIOR

Does your child (check all the child **DOES**):

- Gets along w/ other kids
- Engages in imaginative play
- Rigid play
- Gets along w/ adults
- Cruelty towards animals
- Easily attaches to adults (no sense of stranger danger)
- lies/steals
- Runaway or bolts from adults
- Tantrums beyond age appropriateness
- Invited to play dates or sleepovers
- Has a good sense of humor
- Understands social cues
- Gives into peer pressure
- Sibling conflicts
- Oppositional/defiant towards adults
- shower/brushing teeth/other hygiene issue
- property destruction
- cries easily

SUBSTANCE USE

Any substances abuse your child has tried or you suspect they have tried: ______________________________

____

THERAPUETIC GOALS

What are the current concerns? Please list in order of importance:

1. ____
2. ____
3. ____

What toys does your child choose to play with? ____

____

____

What are your child's favorite activities, hobbies, and how do they spend their free time?

____

What are the strengths of your child/adolescent?

1. ____
2. ____
3. ____
4. ____

Briefly, what are your goals for your child's therapy? How will you know when we have reached those goals?

____

____

____

What other information do I need to know about your child or your family situation? _____________________

____

____

Name of the person completing form: ___________________________ Relation: __________________

Signature: ____ Date: ________________________

Medical Insurance Information

Name of insured: ________________________________ D.O.B. __________________

Policy Holder Name: ______________________________ D.O.B.__________________

Insurance Company: _______________________ Policy holder SSN: ____________________

Relationship to patient: _____________________

Deductible: ______________ Copay: ____________________

Policy I.D. #: ____________________________ Group/Plan #: ________________________

Phone # of Insurance Company for Pre-Certification: ____________________________________

Secondary coverage:

Policy Holder Name: ______________________________ D.O.B.__________________

Insurance Company: _______________________ Policy holder SSN: ____________________

Relationship to patient: _____________________

Deductible: ______________ Copay: ____________________

Policy I.D. #: ____________________________ Group/Plan #: ________________________

Phone # of Insurance Company for Pre-Certification: ____________________________________

Assignment of Benefits:

I authorize payment of medical benefits to the named provider for professional services rendered.

Signature: __________________________________ Date: _______________________

Release for insurance and billing information:

Signature: __________________________________ Date: _______________________

Financial Responsibility:

I accept *FULL* financial responsibility for any and all charges incurred for services provided. This includes *FULL* responsibility for appointments missed OR cancelled within less than a 24-hour notice. This *ALSO* includes Concord Play Therapy the right to legally pursue *ANY & ALL* fees incurred for Non-payment, either through monthly late fees, (if applied), collection fees, and attorney fees. Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure nothing has changed. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. In the event of default in payment, reasonable collection agency fees equal to (25%) shall be added to the amount on the account, plus any applicable court costs.

Signature: _________________________________ Date: ________________________