Heal Together Counseling, LLC
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Concord, NH 03301
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Initial Therapy Intake

Name: ____________________________________ Nickname: ______________________

Date of Birth: _____________________ Age: ____________ Gender: _______________

Address: ____

City: ___________________________ State: ____________ Zip Code: _______________

Phone Number: ____________________________ Lives With: ___________________

Parent/Guardian 1:

Name: ____

Date of Birth: _____________________ Age: ____________ Gender: _______________

Address: ____

City: ___________________________ State: ____________ Zip Code: _______________

Phone: ______________________________ Email: _____________________________

Do you have legal decision-making authority: Yes No Other: ________________

Parent/Guardian 2:

Name: ____

Date of Birth: _____________________ Age: ____________ Gender: _______________

Address: ____

City: ___________________________ State: ____________ Zip Code: _______________

Phone: ______________________________ Email: _____________________________

Do you have legal decision-making authority: Yes No Other: ________________

Parent Relationship Status:

Single Married Partnered Divorced Separated Widow(er)

Emergency Contact (different from parent):

Name: ________________________________ Relationship to client: _____________

Address: ____

City: _______________________ State: _______ Phone: ______________________

Email: ____

Insurance Information:

Insurance Carrier: ____

Phone Number: ____

ID Number: ____________________________ Group Number: __________________

Subscriber's Name: ____________________________ Subscriber DOB: __________

Secondary Insurance Information:

Insurance Carrier: ____

Phone Number: ____

ID Number: ____________________________ Group Number: __________________

Subscriber's Name: ____________________________ Subscriber DOB: __________

Medical Information:

Prior Therapy? Yes No When: ____________ Where:______________________

Primary Care Physician: ____

Primary Care Address: ____

Phone Number: __________________________ Last Physical: __________________

Current Medications (list all):

Current Medication	Reason/Dosage	Prescriber

Medical Diagnosis: ____

Mental Health Diagnosis: ____

Prior Testing: None Neuropsychological Educational Psychological

Testing Date: _______________ Testing Agency: _________________________________

School Information:

School Name: ____ Grade: _____________

Special Education: None IEP 504

Services (circle): OT PT Speech Other: _____________________________________

School Concerns: ____

Dept. of Children, Youth & Families:

Involvement in DCYF: None Prior Current

If yes, reason for involvement: ____

Legal authority to sign for client: ____

CPSW: ____________________________________ Phone: ___________________________

Military Service:

Has anyone in your family served in the military? Yes No

Who: ____

Branch: Army Navy Air Force Marines Coast Guard National Guard

Status: Active Duty Reserves Inactive Ready Reserves Veteran

Has anyone in your family experienced a deployment?

Who: ______________________ When: __________________

Challenges: ____

Observations:

What are your major concerns: __________________________________

____

____

How long have these issues been a concern: ________________________

Does your child have a history of any of the following (circle all that apply):

Suicidal Thoughts Suicide Attempts Homicidal Thoughts Homicidal Attempts

Family History (physical/mental health diagnosis):

Mother: ____

Father: ____

Siblings: ____

Siblings: ____

Other: ____

Behavioral Check List (circle all the apply):

Anxiety	Tantrums	Aggression	Defiant	Crying
Frustrated	Angry	Tired	Energetic	Hyper
Distracted	Confused	Lying	Fearful	Nightmares
Controlling	Running Away	Hiding	Blaming others	Can't sit still
Disorganized	Fidgety	Cruelty to others	Cruelty to animals	Sad
Resentful	Vindictive	Poor sleep	Poor Eating	Poor ADL's
Academic Struggles	Social Struggles	Difficulty communicating	Learning disabilities	Cognitive impairments

About my child:

Likes: ____

Dislikes: ____

Anything else to share:

____

____

____

____

Referred By:

Name/Facility: ____

Address: ____

May I Thank Them? Yes No