

ASSOCIATED COUNSELING PROFESSIONALS

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CHILD AND ADOLESCENT INTAKE FORM

To be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand your child. It, as all communications with your therapist, will be kept confidential to the full extent of Nebraska law.

BACKGROUND INFORMATION

Child's Name: _____ Date of Birth ____/____/____ Age ____

Child Lives With (check one): Both Biological Parents _____ Mother _____ Father _____ Other _____

If parents are divorced, describe custody arrangements: _____

Child's Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact (other than parent): _____ Telephone Number _____

Custodial Parent's Contact Information:

Telephone _____ (Home) _____ (Cell) _____ (Work) _____ (E-Mail) _____

Circle the best way to contact you for appointment reminders: Home _____ Work _____ E-mail _____ Cell _____ Don't contact

May we leave a message? Yes _____ No _____

INFORMATION ABOUT CHILD'S MOTHER

Mother's Name: _____ Age: _____ Race: _____

(Address, if different from child) _____

Employer: _____ Occupation: _____ Hours/week: _____

Can you be contacted at work by telephone? Yes _____ No _____

Circle the best way to contact you: Telephone - _____ (Home) _____ (Cell) _____ (Work) _____ (E-Mail Address) _____

Describe any physical problems you have that require medication or physical care: _____

Are you currently receiving medical treatment? Yes _____ No _____ Physician _____

Medication(s) currently using _____

Previous Counseling/Therapy? Yes _____ No _____ If yes, with whom? _____

How long? _____

INFORMATION ABOUT CHILD'S FATHER

Father's Name: _____ Age: _____ Race: _____
(Address, if different from child) _____

Employer: _____ Occupation: _____ Hours/week: _____

Can you be contacted at work by telephone? Yes _____ No _____

Circle the best way to contact you: Telephone - _____
(Home) _____ (Call) _____ (Work) _____ (E-Mail Address) _____

Describe any physical problems you have that require medication or physical care: _____

Are you currently receiving medical treatment? Yes _____ No _____ Physician _____

Medication(s) currently using _____

Previous Counseling/Therapy? Yes _____ No _____ If yes, with whom? _____

How long? _____

PLEASE PROVIDE A COPY OF YOUR DIVORCE DECREE TO YOUR THERAPIST, IF APPLICABLE

FAMILY MEMBERS

List all people now living in the household:

Name	Relationship to Child	Age	School Grade Completed	Occupation

DESCRIBE THE ISSUE the child is having. If possible, list question for which answers are sought:

Check What Applies:

_____ Anger _____ Religious/Spiritual Concerns

_____ Depression _____ Sexual concerns

_____ School Problems _____ Thoughts of suicide

_____ Family problems _____ Trouble making decisions

_____ Fearfulness _____ Unhappy most of the time

_____ Marital problems _____ Use of alcohol

_____ Physical problems _____ Use of drugs

_____ Problems with social relationships _____ Work

_____ Problems with children _____ Worry

Other _____ Legal issues

_____ Withdrawn or Isolated

CHILD'S MEDICAL HISTORY

List child's sicknesses, operations and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever or was delirious; difficult pregnancy or delivery:

List any medications your child is on - _____

Have there been any previous psychological, psychiatric, neurological or EEG evaluations? Yes _____ No _____

If so, please list names and dates of contact: _____

Describe previous speech or hearing therapy, if any: _____

What is the date of your child's last physical examination? ____/____/____ Physician's Name _____

ACADEMIC/SCHOOL INFORMATION

School Name: _____ Grade: _____ Teacher: _____

How many previous schools attended, with dates: _____

Has child ever repeated a grade? Yes _____ No _____ If so, when? _____

How does your child get along with peers and authorities at school? _____

Describe difficulties in learning at school: _____

Please provide copies of all special testing(s) he/she has needed for educational or psychological purposes.

Have other family members had learning difficulties? Yes _____ No _____ What? _____

Optional: Describe what your child likes to do for fun, special interests, hobbies, etc.:

Optional: Describe your child's religious background (denomination, church membership, attendance, spiritual training, bible reading, prayer, etc.):

I learned about Associated Counseling Professionals from: (Yellow Pages, Internet, friend, doctor, etc. If you could provide the name, address and telephone number, if known):

May we send a thank you note to this person? Yes _____ No _____

Your Signature: _____ Date ____/____/____

INSURANCE INFORMATION:

Insured's Name: _____ Social Security Number: _____

Address of Insured: _____

City State Zip Code

Telephone Number(s): _____

Home

Cell

Work

Insured's Date of Birth

Employer: _____

INSURANCE POLICY INFORMATION - Please give your insurance card to the support staff to photocopy. Office Insurance Policy: We will file your insurance, when possible, if we cannot file your insurance, we will give you the forms you need to file it. If we are unable to determine your benefits prior to your first visit, we require payment for the first visit in full.

Primary Insurance Company Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number to Verify Benefits: _____ Plan Name: _____

Identification Number/Social Security Number: _____ Policy/Group Number: _____

Champus Status (military): _____ Active _____ Retired _____ Deceased _____

I hereby assign all benefits otherwise payable to me to Associated Counseling Professionals, as payment towards the charges incurred for services rendered. I further instruct the insurance company named above to issue a check directly to Associated Counseling Professionals. I also authorize Associated Counseling Professionals to release any information pertinent to services rendered to any authorized representative of my insurance company, adjuster or review agency.

SIGNED BY:

DATE:

X _____ X _____

BILLING INFORMATION:

If another individual or agency is responsible for payment, please complete the information below --

Responsible Party Name: _____ Relationship to Client: _____
Social Security Number: _____
Address: _____
City State Zip Code
Home Phone Number: _____ Work Phone Number: _____ Cell Phone Number: _____
Employer: _____ Percentage of Bill Responsible For: _____

Please sign here if you read and understood ACP's "After-Hours Emergency Service" found in the Welcome Brochure --

Signature of Client Date _____

Referred By/How Did you Hear About Us? (Check One)

____ <i>I am a former client returning</i>	____ <i>Relative</i>	____ <i>Friend</i>
____ <i>Insurance Company/Managed Care</i>	____ <i>Minister/Priest/Rabbi</i>	____ <i>School</i>
____ <i>Dex Yellow Pages</i>	____ <i>US West (under hypnosis)</i>	____ <i>Internet</i>
____ <i>Yellow Book</i>	____ <i>Physician: Dr. _____</i>	____ <i>EAP</i>
____ <i>Other _____</i>		

FOR OFFICE USE ONLY:
Benefits -

EAP: _____	MANAGED CARE: _____
# of Sessions: _____	Deductible: \$ _____
Self Pay: \$ _____	Co-pay: \$ _____
	Number of Sessions: _____/Year
	Authorization Needed: ____ Yes ____ No

THERAPIST: _____ DSM CODE: _____ ACCOUNT #: _____
