**YOUTH INTAKE INFORMATION FOR COUNSELING SERVICES **

Patient: _____DOB:_____
Referred by:_____
Mother's (or guardian's) name:_____DOB:_____
Billing/Mailing Address:_____zip:_____Home #:_____
Employer:_____Cell/Work phone:_____
Preferred means of contact: _____
Father's (or guardian's) name:_____DOB:_____
Billing/Mailing Address:_____ Home phone:_____
Employer:_____Work/cell phone:_____
Preferred means of contact: _____
Name and ages of siblings living at home: _____
_____ _____
_____ _____
If parents divorced, what is custody/visitation arrangement? _____
_____
Child's School:_____ Grade:_____Teacher:_____
Physician:_____Date of last exam:_____
Any medical conditions?_____
Medications?_____
Allergies?_____
Previous mental health treatment (dates and provider):_____
History of any familial mental disorders:_____
_____
History of any familial substance abuse/addiction:_____
_____
History of any hospitalizations/surgeries: _____

History of any separations/losses: _____
_____
History of any neglect/trauma/abuse: _____

Please Describe:
Presenting problems/concerns:_____

Child's personality:_____
_____
General health:_____
Pregnancy/birth complications:_____
Early development:_____
_____
Any sleep/eating problems:_____
_____
School functioning:_____
_____
Peer relationships:_____
_____
Sibling relationships:_____
_____
Emotional concerns:_____
_____

Behavioral concerns:_____

_____

Fears/habits of concern:_____

_____

SpecificSensitivities_____

_____

Child's strengths:_____

_____

Special talents/interests:_____

_____

Primary care giver first three years: _____

_____

Relationship with parent(s): _____

_____

Other close relationships: _____

_____

Form of discipline used: _____

_____

Response to discipline: _____

_____

Other concerns:_____

_____

Desired outcome of therapy? _____

_____

Referred by:_____Do you wish to bill insur.?_____*
Primary Insured:_____ DOB:_____
Primary Ins. Carrier:_____Phone:_____
Address:_____Claim/Auth #:_____
Member ID #:_____Group#:_____
Contact person (if applic.):_____Co-pay :_____

Secondary Insur. (if applic.):_____Phone #:_____
Name of Insured:_____DOB:_____
Address:_____Claim/Auth#:_____
Member ID:_____Group# :_____

Insurance Billing: I will bill your insurance company for you. Please sign below if you wish to authorize our office to electronically process your claim and to authorize the disclosure to your insurance company the information they require for payment which typically includes the information listed above as well as a clinical diagnosis, dates of service, and treatment modality. Please note they may request to review your counseling notes. It remains your responsibility to comply with the requirements of your plan, pay all co-pay amounts, deductibles, keep track of the number of authorized sessions, inform me in a timely manner of insurance changes, and to pay for any services, copays, or deductibles not covered by your insurance plan. My hourly rate is $90/hour with a $5 discount available when your account is paid in full at time of serve, or the current negotiated rate your plan allows if I am in-network.
Signature: _____Date:_____

*Under HIPPA you have the right to request that I not bill your insurance. Please sign to waive Insurance billing: _____ Date: _____