Jina Wright, MS, LMHP

CHILD INTAKE FORM

GENERAL INFORMATION

I recognize this is a very long form and takes time to complete; however, it is very helpful. It allows me to get to know your family, as well as provide a chance for you to know your child better and clarify your goals. If you have questions and/or feel uncomfortable answering a question, please write a comment in the margin and we'll talk about it at the next session. Thank you!

Child's Name:_____ Today's Date:_____

Child's age:_____ Date of Birth (DOB):_____

Address:_____

_____

Parent's Name: _____ Parent's Name: _____

Home phone:_____ May I leave a message? Yes No

Cell phone:_____ May I leave a message? Yes No

Work phone:_____ May I leave a message? Yes No

Email: _____ May I email you? Yes No

(For appointment scheduling purposes only, as email is not considered a confidential medium of communication.)

INSURANCE INFORMATION

Insurance Company:_____ Name of Insured:_____

Insured's Date of Birth: _____

Insured's Employer:_____ Policy Name: _____

Insured's Member ID #:_____ Insured's Group #:_____

Insured's Relationship to the Client:_____ Authorization # (if needed):_____

Customer Service Phone # (for MH/SA): _____

Address for Submitting Claims: _____

Who referred your child to my private practice? Please provide agency/professional's name & tel. #:

_____

May I contact the agency/person to thank them for referring you? Yes No Please initial:_____

What is the <u>main reason(s)</u> you're seeking help for your child? (Include how long he/she's had these symptoms or problems):

_____

_____

_____

What are your <u>hopes</u> regarding your child's therapy?_____

_____

_____

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems? _____

_____

_____

Has your child ever been treated for any of the following? If so please circle and describe:
Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions:

_____

_____

_____

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

_____

_____

_____

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

_____

_____

Please list your child's current prescription medications with dosage (psychiatric and general health):

_____

_____

_____

Please list any previous psychiatric medications (with dosage and dates): _____

_____

Do you suspect or know your child drinks alcohol or uses recreational drugs? If so, what kind & how often? _____

_____

Do you or anyone close to your child consider his/her use to be a problem? Yes No

Who is your child's primary care physician? _____

Who is your child's psychiatrist (if applicable)? _____

When was your child's last complete physical exam (mo/year)? _____

How many times a week does your child exercise? _____ What type & how many minutes? _____

_____

What types of food does he/she often eat? _____

_____

YOUR CHILD'S FAMILY

	BIOLOGICAL MOTHER	BIOLOGICAL FATHER
Current age, or If deceased date, age, & cause of death		
Country of Origin		
Occupation		
Religious/Spiritual Affiliation (if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? _____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:

_____

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

YOUR CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth

Were there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe:

_____

Medications used during pregnancy? Please list: _____

Smoking? Yes No How much? _____

Alcohol intake? Yes No How much? _____

Drug intake? Yes No How much? _____

Length of pregnancy?_____Weeks Age of mother at birth: _____ Birth weight: _____

Were there any complications during delivery? If so, please describe: _____

_____

Length of stay in the hospital? Mother: _____(days) Child: _____(days)

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each):

Turn over _____ Crawl _____ Stand Alone_____ Walk Alone _____

First Words_____ First Phrases_____

Toilet trained? Yes No If yes, days?_____Nights? _____

Has your child wet or soiled himself after being trained? Yes No If yes, until what age?_____

Enjoyed cuddling? Yes No Fussy, Irritable? Yes No More active than other babies? Yes No

If your child has siblings, was development different in any way? Explain:_____

_____

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

School name: _____Public or Private (circle one)?

Street Address: _____

School District/County? _____ Phone: ___(____)_____

What preschool experience did your child have? _____

Where any problems detected in your child's kindergarten screening? Yes No If so, please explain:

_____

Is your child in a regular classroom? Yes No Does your child have an IEP ? Yes No

Has your child ever received tutoring? Yes No If so, please explain: _____

What are your child's typical grades? _____

What are your child's strongest and weakest points academically? _____

_____

Are you satisfied with your child's educational program? Yes No Please explain: _____

_____

Home/Family Life

What are 5 things you enjoy most about your child? _____

_____

What are some activities you engage in as a family? _____

Does your child participate in any religious or faith based groups? _____

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques? _____

_____

What are <u>your</u> strengths personally and as a parent? _____

What are some of <u>your</u> areas of needed growth? _____

What are your <u>child's</u> strengths (things he/she is good at)? _____

What are your <u>child's</u> areas of needed growth? _____

Social and Community Engagement

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activities is he/she involved? _____

How does your child get along with other children? _____

Who are some of your child's closest friends (first name) _____

_____

Your Child's Symptoms or Problems

How much are <u>each</u> of the following areas currently a problem for your child?

	Not at all	**A little**	**Somewhat**	**Considerably**	**A lot**
	1	**2**	**3**	**4**	**5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? Yes No
(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No

If yes, please describe:_____

_____

_____

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: _____

_____

_____

_____

_____

Consent for Treatment

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by Jina Wright, LLC, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of nineteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____

Signature of Client, Parent/Guardian Date

Relationship to Patient (if applicable):_____

Consent for Use and Disclosure of Health Information

I give my consent for the use or disclosure of mine or my child's protected health information (PHI) by the staff of Jina Wright, LLC for the purpose of treatment, payment, and healthcare operations. By signing this form, I am agreeing to let Jina Wright, LLC use my information and send it to others. The Notice of Privacy Practices explains this in more detail. **I have received the Notice of Privacy Practices and understand I should read it before signing this consent.**

- ✧ I understand that if I do not sign this consent form agreeing to what is in the Notice of Privacy Practices, Jina Wright, LLC cannot treat me and/or my child (ren).
- ✧ Jina Wright, LLC reserves the right to change its privacy practices. In this case, all current or revised Notices of Privacy Practices may be obtained from Jina Wright, LLC's Privacy Officer.
- ✧ I have a right to request (in writing) a restriction of how my PHI is used or disclosed to carry out treatment, payment, or healthcare operations. Jina Wright, LLC is not required to agree to the restrictions that I may request. However, if Jina Wright, LLC, Inc. agrees to a restriction that I request, the restriction is binding on Jina Wright, LLC. Additionally, I understand that I have the right to revoke this consent, in writing, at any time.
- ✧ My PHI means health information, including demographic information, collected from me and created or received by my physician or health plan. This PHI relates to my past, present or future physical or mental health or condition and identifies me or my child.

_____ _____

Signature of client, parent or legal guardian Date

_____ _____

Witness Client's Name

❑ Copy given to Client or Parent/Legal Guardian