Prairie Village Therapy Services, LLC

Child Intake

Date: _____ Therapist: _____

Child's Name:_____DOB:_____email:_____

Parent's Email:_____

Address of Primary Residence: _____City:_____

Zip: _____

Age: _____ Birth Date: _____ School _____Grade _____

People living in Primary Residence:_____

Name of Emergency Contact: _____Phone:_____

How did you hear about me? _____

Child's Medical Doctor (first and last name): _____ City: _____.

Month and Year of last Physical: _____

When healthcare professionals work together it benefits you. May we have your permission to update your child's medical doctor regarding their care at this office? _____ Initial here

HISTORY OF PRESENT PROBLEM:

Purpose of this appointment:

_____

_____

_____

Have they ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:

_____

_____

PAST HISTORY

Did your child ever have: (Place a check mark by conditions that apply)

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

Have they been treated for any health condition by a physician in the last year? ____ Yes____ No

If yes, describe:

_____

What medications or drugs are they taking? (List name and dosage)

_____

_____

Please list any other health problems they have, no matter how insignificant they may be:

_____

_____

Have they been in counseling before? No__ Yes__ If yes, year and therapist name:

_____.

Have they ever been hospitalized for substance abuse or inpatient psychiatric treatment?

No__ Yes__ if yes, where and year: _____

SOCIAL HISTORY:

Do they drink alcoholic beverages? _____ If so, how much per week?

_____

Do they use any tobacco products? _____

Do they consume caffeine? If so, how much per day:

_____

Do they exercise? YES/NO

Do they sleep well at night? _____ If no, why not?_____.

What are their hobbies? _____.

What percentage of time during the day (at home or at school or away from home) do they spend:

Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

FAMILY HISTORY:
PARENTS OF CHILD BEING SEEN:

Father: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____

Name:_____

Address:_____

IS FATHER REMARRIED? YES ____ NO____ IF SO, NAME OF STEP-PARENT LIVING IN HOME:_____.
Is Father living with someone? Yes ____ No____ IF YES, NAME OF CO-HABITANT: _____.

Mother: living ___ deceased ____ (check one) Current age if still living: _____ Cause of death and age at death if deceased: _____

Name:_____

Address:_____

IS MOTHER REMARRIED? YES___ NO___ IF YES, NAME OF STEP-PARENT LIVING IN HOME:_____.
Is Mother living with someone? YES____ NO____ IF YES, NAME of COHABITANT: _____.

FAMILY HEALTH HISTORY: (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother of the child):

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

AUTHORIZATION AND RELEASE: I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE found in the waiting room.

Parent or Guardian Signature: _____

Date: _____

IF APPLICABLE,

According to State Law, **A COPY OF THE DIVORCE DECREE STATING THAT THIS PARENT HAS LEGAL RIGHT TO SEEK MEDICAL CARE FOR THIS CHILD MUST BE ON FILE WITH THE THERAPIST. I certify that I have brought a copy of the divorce decree for this file.**

Parent or Guardian

Signature:_____

Date:_____

Case History Child's Name _____ Date _____

1. What is your major concern?

_____

_____

_____

_____

Other concerns:

_____

_____

_____

_____

2. If this is a recurrence, when was the first time you noticed this problem?_____

How did it originally occur?_____

_____

_____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

If yes, when and how?

_____

_____

3. How frequent is the condition? Constant _____ Intermittent ____

What causes the problem to come on/get worse?

_____

_____

_____

4. Are there any other conditions you would like to discuss?

Yes _____ No _____. If yes, describe:

_____

_____

Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

_____

5. Is there anything you can do to relieve your child's major problem? Yes ___ No ___.

If yes, describe:

_____

If no, what have you tried to do that has not helped?

_____

_____

6. What makes the problem worse?

_____

_____

9. Remarks:

_____

_____

NO SYMPTOMS/STRESS — EXTREME SYMPTOMS/STRESS

|_____|

Please place an "X" on the line above to indicate level of problem.

Signature of Therapist:_____