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CLIENT INTAKE FORM

Today's Date _____/_____/_____

CLIENT INFORMATION

Last Name	First	Middle	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security - -	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	Cell Phone No. ( )	Home Phone No. ( )
City	ZIP Code	Preferred method of contact:	Text Messaging ❑Yes ❑No

Referred to Provider by (Please check one box) ❑ Dr. ____________ ❑ Insurance Plan ❑ Website

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Occupation			Cell Phone No. ( )
Employer	Employer Address		Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Name of EAP: ____________
Insurance Company Phone Number: ( )	Phone No. of EAP: ( )	Total Annual EAPs allowed? ______

Please Select Your Primary Insurance Company

❑ Aetna ❑ Beech Street ❑ Blue Cross ❑ Blue Shield ❑ Blue Cross/Blue Shield
❑ College Health ❑ CIGNA ❑ Holman ❑ Magellan ❑ Medicare
❑ Managed Health Network ❑ PacifiCare ❑ Tricare ❑ United Healthcare
❑ Value Options ❑ Other ______________________________

What is the authorization number? ❑ Self Pay/Amount

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

(Please complete the other side of this page.)

PLEASE READ THE FOLLOWING CAREFULLY AND INITIAL EACH SECTION BELOW:

___I hereby consent to treatment for ____________________________________(patient). Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

___ The fee for services is $115-$140 for individual therapy and $150 for conjoint (couples/family) therapy.

___I understand that I am responsible for my fee payment at the beginning of each appointment. All payments shall be made to "Rancho Cucamonga Therapist".

___I understand that all returned checks will be subject to an additional $25 NSF fee.

___I understand that all appointments not canceled 24 hours prior to the session will be billed to the client.

___I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be obtained. I will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

___I consent to the use of a diagnosis in billing, and I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

___I authorize the payment of insurance benefits to Rancho Cucamonga Therapist.

X

CLIENT/GUARDIAN SIGNATURE DATE

Child Intake

Please provide the following information about your child:

Childs Full Name: ____

Nick Name: ____

Birth Date: _______________ Today's Date _______________

Behavioral Excesses:

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:

What does your child do that you like? What does he /she do that other people like?

Others Concerns:

Do you have any other concerns about your child or your family that you have not mentioned yet.

Child’s Name: ____

Nickname: ________________________________ **Birthdate:** ______

Treatment Goals:

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Please provide the following information about your child:

Family History:

The name of the child's biological parents:

Mother: _________________ Father: __________________

Who has legal guardianship of your child? _________________________

Who does your child currently live with? ___________________________

Names	Ages	Relationship to child	Grade/Job

Who are your child's significate others NOT living with your child?

Names	Ages	Relationship to child	Grade/Job

Please describe any past counseling that either your child or any family member has had

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? ____ If yes, Please describe:

Child’s Name: ____

Nickname: _______________________________ **Birthdate:** ______

Education History:

What school does your child attend? ____________________________
Address: ____
Phone: _________________ Teachers Name: __________________________
Current Grade: _____________.

What does your child's teacher say about him/her?

Other schools attended (including Pre-school)

Has your child ever repeated a grade? _____ If so which one(s) __________

Has your child ever recieved special education services?

Has your child experienced any of the following problems at School?
(Place check to the left of all that apply)

* fighting
* suspension
* gang influence
* lack of friends
* learning disabilities
* incomplete homework
* drug/alcohol
* poor attendance
* behavior problems
* detention
* poor grades

Medical History:

What is the name of your child's medical doctor? ______________________
Address: ____________________________ Phone: ________________

Date of your child's last medical examination: __________________________
Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? _____ If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? _____ If so, Please describe them:

Child's Name: ____

Nickname: ________________________________ **Birthdate:** ______

Has your child experienced any of the following medical problems?
(Place Check to the left of all that apply)

* A serious accident * Hospitalization * Surgery * Asthma
* A head injury * High fever * Convulsions/seizures
* Eye/ear problems * Meningitis * Hearing problems
* Allergies * Loss of consciousness
* Other ____

Please list any current medical problems or physical handicaps:

____
____
____
____

Please list any medications your child takes on a regular basis:

____
____
____
____

Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal? ____ If so please describe:

____
____
____

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else? ____ Has he/she ever purposely hurt himself or another? ___
If yes to either question please describe the situation:

____
____
____

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? ____ If yes, please explain:

____
____
____
____

Finally, what are some of the things that are currently stressful to your child and his/her family?

____
____
____
____