CARA ANDERSON CHILD AND FAMILY INTAKE FORM

PLEASE FILL OUT COMPLETELY.

Patient Name:______________________________ Social Security #:__________________________

Mailing Address:____

City/State/Zip____

Home Phone #________________ Other Phone # ______________

OK to leave message? YES/NO YES/NO

Date of Birth:_________________ Referred by:___________________________________

Sex: FEMALE / MALE / _____ Primary Care Physician:__________________________

Child lives with: MOTHER/FATHER/BOTH OTHER (Describe):

Mothers Name: _________________________ SS # __________________ Phone: ______________

Fathers Name: __________________________ SS # __________________ Phone: ______________

School_________________________________ Grade____________________

Emergency contact___________________________ Phone # ____________________________

PRIMARY INSURANCE

Insurance Co.:________________________

Policy Number: ______________________

Group Number:_______________________

Customer Service Phone Number:

____

Policy Holder's Name:

____

Relationship to you:__________________

Policy Holder date of birth:_____________

Policy Holder Social Sec #:_____________

SECONDARY INSURANCE

Insurance Co.:__________________________

Policy Number:_________________________

Group Number:_________________________

Customer Service Phone Number:

____

Policy Holder's Name:

____

Relationship to you: _____________________

Policy Holder date of birth:_________________

Policy Holder Social Sec #:_________________

PERSON RESPONSIBLE FOR PAYMENT:

Name: ____________________________________ Relationship to patient:____________________

Date of Birth: ____________________ Drivers License #: ________________________

Mailing Address: ____

Social Security number: ____________________ Home Phone: _______________________

Employer: ____________________________________Position______________________________

Work Phone: _______________________

I hereby authorize direct payment from my insurance company to my provider. I understand that I am responsible for all costs of medical treatment. I certify that all the above information is correct and **I have read and will subscribe to the payment policy on my practitioner's disclosure form.**

____ ____________________________________

Signed (Person responsible for payment) Date

CHILD'S MEDICAL HISTORY

Is your child taking medication? YES / NO

ALL CURRENT MEDICATIONS (Including vitamins, herbal supplements and over-the-counter drugs):

Medication	Dosage	For What Purpose?	Date Started

Has your child ever had any of the following?

Visual problems	YES/NO	Broken Bones	YES/NO
Hearing problems	YES/NO	Head Injury	YES/NO
Allergies	YES/NO	Serious infections	YES/NO
Problems with coordination	YES/NO	Soiling	YES/NO
Weight loss	YES/NO	Bedwetting	YES/NO
Speech problems	YES/NO	Chronic illness	YES/NO
Seizures	YES/NO	Other:	

List any illness or injuries for which the child required hospitalization or surgical operation:

ILLNESS	DOCTOR	DATE	HOSPITAL

FAMILY SITUATION

CURRENT FAMILY STATUS: Single parent involved engaged cohabitating married
Separated divorced widowed remarried

MARRIAGES, SIGNIFICANT RELATIONSHIPS, AND CHILDREN:

Partner/Spouse	Beginning Year	Ending Year	Names/ages of children from relationship	Where/with whom do they live?

MOTHER'S EDUCATION: ________________________________ AGE: ____________________

EMPLOYER: ______________________________________ OCCUPATION: ___________________

FATHER'S EDUCATION: ________________________________ AGE: ____________________

EMPLOYER: ______________________________________ OCCUPATION: ___________________

Are any family members experiencing significant medical problems? YES ? NO

If yes, please describe: ____

Specify child's Alcohol/Drug/Tobacco/Caffeine use:

Past: ____

Present:____

MENTAL HEALTH HISTORY

Has your child had mental health problems in the past (please explain)?

____

____

____

Has your child sought treatment for this or other mental health problems? Was it helpful? ____________

____

Were your child ever hospitalized for psychiatric reasons? If so, when and where?

____

LIST ALL PREVIOUS AND CURRENT ***PSYCHIATRIC*** MEDICATIONS:

Drug Name	Strength	Times/Day	Currently Using?	Results

Have any of your relatives had problems with their mental health? If so, please describe: _____________
____

GOALS FOR THERAPY

What would you like to see happen as a result of your and your child's work here? __________________

____

____

____

____

____

DEVELOPMENTAL HISTORY

Pregnancy

During the pregnancy, did the mother experience any difficulties (such as German Measles, RH incompatability, false labor, etc.)? If yes, please explain: ____

Were any drugs (prescribed or non-prescribed), alcohol or tobacco taken during pregnancy?
____

Were there any problems with other pregnancies, (miscarriage, difficult delivery)? Please explain:

Delivery

Duration of pregnancy: _____________ Duration of labor: _______________Birth Weight: ___________

Describe any difficulties with the delivery (Caesarian section, breech birth, etc.):
____

Following birth, did the infant have any difficulties (such as trouble starting to breathe, infections, etc.)?

Development

How old was the child when he/she:

Smiled _____________ sat without support____________________ stood ____________________

walked without support________________ used single words (other than mama, dada) ______________

Combined two words into simple phrases___________________ spoke in short sentences ____________

Was bladder trained (day) _______________ (night) _____________ was bowel trained _____________

Comment on how you found the child to look after:

As an infant _______________________________ as a toddler __________________________________

Was the child a cuddly infant or toddler?

PRESCHOOL HISTORY

Name of Program **For how Long**

List any preschool programs your child has attended: ______________________________

____

List any daycare centers your child has attended: ______________________________

____

Has a private babysitter cared for your child? YES/NO

Has your child's behavior been of any concern at the preschool or daycare? YES/NO

If yes, what have the concerns been?

SCHOOL HISTORY

Name of present school: ______________________________

Teacher: ______________________________Grade Level ______________

City **Grade Level**

Please list other schools attended: ______________________________

____

Has your child's behavior been of any concern at school? If yes, please explain: ______________

____

Has your child needed any special help at school? If yes, please explain: ______________

GENERAL INFORMATION

Has the child experienced any serious upset? YES/NO If yes, what kind: ______________

____

Has the child suffered any significant losses? YES/NO If Yes, please explain: ______________

____

Is the child clingy? YES/NO Comments? ______________________________

____

Any problems with eating or appetite? YES/NO Please explain: ______________

____

Does the child have any particular fears? YES/NO Comments: ______________

____

Any problems with sleeping? YES/NO Comments: ______________________________

____

Any problems with discipline? YES/NO If yes, please describe: ______________

____

How active is the child? ______________________________

____

Please add any information you feel would be helpful:

THERAPIST'S NOTES (for office use only)

Therapist Name: ______________________________

Date	DX code	Diagnosis	Counselor signature