CHILD INTAKE FORM:

Date Of Scheduled Intake _____

Name_____ Male /female Date of Birth _____ AGE _____
Address
_____ Phone:_____Work _____
(Street) City State (Zip)

Emergency contact number: _____ / Alternative family member number _____

Insurance Information: _____Subscribers ID# _____
Insured's name _____ If other than client please include DOB_____

Medicaid # _____

Client accompanied at intake by
_____
Name and relationship

Who referred you to my private practice _____

Name of School_____Grade _____
Has the child ever repeated a grade or experienced academic problems? Does the child have an IEP ?
Please explain:
_____
_____
_____
Has the child /family moved or experienced frequent school changes_____

Has the child/family experienced changes in living situation brought on by separation / divorce, DSS involvement, parental illness or deployment: If so please explain: (circumstances of change , how old was the child, and what are the living and/or visitation arrangements)
_____
_____
_____
_____

Has your child ever experienced trauma or loss ? explain:
_____

_____
_____
Has the child received counseling in the past? Yes/No
Previous Counselor Name: _____ Dates of service_____
Was it helpful? Yes/No How long did child receive services_____
Does the child receive psychiatric medication? Yes/No
Name of provider
_____
Current Medication:_____
Would you like for this therapist to consult previous counselor or obtain records? If so please sign release.
Include information you feel is helpful regarding treatment, such as reasons for treatment, diagnosis, tx that was helpful or not helpful:_____
_____
_____
Does the child have any chronic health conditions: yes/no _____
_____

Primary Care Physician_____
Address:_____ phone number
_____

How would you describe your child's sleep? _____
_____ difficulty falling asleep _____fall asleep, but wake up several times during the night
Typically gets _____ hours of sleep on average per night.
How is your child's appetite_____

PARENTS

Mother's Name_____	Father's Name _____
Date of Birth _____	Date of Birth_____
Address_____	Address_____ _____
Home Phone_____	Home Phone _____
Employment_____	Employment _____
Work Phone _____	Work Phone_____

Person Responsible for Account _____

Others Living in Home with child

Name	Age	Relationship
Name	Age	Relationship

Name Age Relationship
Name Age Relationship
In cases of divorce, how is legal custody assigned?
Joint Sole custody, mother Sole custody, father Other Custodian

I certify that I have legal authority to obtain treatment for this child and that I wish Julia H Tabor, LPC to provide assessment and counsel for my child. I also agree to the informed consent forms and understand HIPPA forms. Please notify therapist if child's insurance changes during duration of treatment.

Signature Relationship Date
_____ _____ _____
_____

It is helpful to know any psychiatric conditions that run in your family. please list family history of disorders and relationship to client. Please note if you do not feel comfortable listing relationship you may leave blank.

Disorder	Relationship to client
_____ Depression	_____
_____Mood disorder/bipolar	_____
_____ ADHD	_____
_____ Anxiety	_____
_____Substance Abuse/Addiction	_____
_____Obsessive Compulsive Disorder	_____
_____Schizophrenia	_____
_____psychotic Disorder	_____
_____PTSD	_____
_____Personality D/O	_____

_____other

Please list your child's strengths
:_____
_____

Has your child ever had an out of home placement?
_____

Does your child ever threaten to hurt themselves or others? Yes/No
Explain:_____
Has your child ever been hospitalized due to psychiatric concerns? Yes/NO
Please provide dates and explain:
_____
_____
_____

Please check any emotional /behavioral concerns you have regarding your child:

____depression
____anger management
____aggression
____problems associated with adjustment
____grief, Loss
____trauma
____victim of abuse (sexual, physical, psychological), family violence_____
____ victim of neglect _____
____adjustment associated with separation/divorce of parents
____crying spells
____separation anxiety
____social problems
____peer conflict
____Lying
____stealing
____Sleep difficulties
____Drug/Alcohol Abuse/Use please explain_____
____Eating disorder
____Sexual Assault
____temper tantrums
____mood swings
____anxiety, fears , worries
____delinquent behavior
____fatigue or loss of energy
____inattention
____poor academic performance
____family conflict, communication problems
____sibling conflict
____Isolation
____Disrespect
____Deviance, refuses to comply with request by adults
____Disruptive behaviors at school
____impulsive, poor decision making
____Disruptive behaviors at school
____run away risk _____
____suicidal ideations/ _____
____ risky behaviors _____
____cutting, self-mutilation_____
____sexual activity
____Attachment Disorder
____Self Esteem
____Nightmares

____Stress management

Please list below any other concerns or explain in more detail why you are seeking services, what you are most concerned about, the history of these problems and when/how long these problems have been occurring/or manifest itself in your child's life or family life.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

You may also list any questions or concerns you want addressed or answered related to the therapy process, policy or related to your child's treatment:_____
_____
_____
_____
_____

Julia H Tabor, LPC..... COMMUNICATIONS AND Privacy

Please check all that apply:

Home Telephone_____

Okay to leave message with detailed information
Leave message with call-back number only
Do not leave message

Work Telephone_____

Okay to identify myself to receptionist or co-worker
Okay to leave message with call-back name and number
Do not leave message

Cell Phone_____

Okay to leave message with detailed information
Leave message with call-back number only
Do not leave message

Written Communication_____

Okay to mail to my home address
Okay to mail to my work/office address
Okay to fax to this number

Necessary to call me before faxing at this number

Whom may I thank for this referral?

Name:

Address:

By signing below, I agree to all of these checked above.

_____ Date_____

_____

Regarding Patient:

Name _____Date of Birth:_____

I,_____ , hereby give permission to Julia H Tabor, LPC

to: RELEASE INFORMATION TO: AND/OR OBTAIN INFORMATION FROM (in verbal or written form):

_____

(Name of referring doctor, agency, attorney, school counselor, therapist, etc.)

Address or Phone number, fax (if known)

_____

INFORMATION TO BE DISCLOSED/OBTAINED:

__ Summary of evaluation and treatment
__ Pervious Mental Health Treatment
__Social/family history
__Medical History and physical exam
__Psychiatric evaluation
__Alcohol and substance abuse information
__Psychological evaluation
__Laboratory test results
__Progress notes
__Ongoing verbal exchange regarding treatment and progress
__School records, grades, test scores, teacher observations
__Diagnosis
__Medication information
__treatment recommendations
__other

I understand this information will be used for:

_____Evaluation and treatment planning

_____Referral

INFORMATION I DO NOT WISH TO BE DISCLOSED: _____

_____

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to

receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above.
Any information on this form that is unclear to me has been explained to my satisfaction by Julia. I understand the information to be released, the need for information, and that there are statues and regulations protecting confidentiality of the authorized information. I understand this consent is voluntary. It will expire one year from the date of signature noted below. I may revoke this authorization in writing.

Date Signature of patient, parent, guardian or authorized agent

_____

Please note that confidentially and privacy of information is very important. If this form is filled out before arriving at my private practice, please make sure it is kept confidential and in a safe place.If at any time you have questions regarding confidentially, HIPAA compliance or limits to confidentially please let me know.