Barbara Howell, LMFT

New Client Questionaire for Parents/Children

Date: _____

Parent/Guardian's Name (Last, Middle Initial, First):

_____

Date of Birth: _____ Age: _____

Street Address: _____ City: _____

State: _____ Zip: _____

Home phone: _____ Alternate phone: _____

Email: _____

Alternate Email: _____

Please indicate the means by which you prefer to be contacted. You may check more than one:

Phone: ____ Text: ____ Email: ____ Regular Mail: ____

If you would prefer to be contacted at a phone number, email, or address other than what is listed above, please provide that information here:

_____

Parent/Guardian's Name (Last, Middle Initial, First):

_____

Date of Birth: _____ Age: _____

Street Address: _____ City: _____

State: _____ Zip: _____

Home phone: _____ Alternate phone: _____

Email: _____

Alternate Email: _____

Please indicate the means by which you prefer to be contacted. You may check more than one:

Phone: ____ Text: ____ Email: ____ Regular Mail: ____

If you would prefer to be contacted at a phone number, email, or address other than what is listed above, please provide that information here:

_____

Child's Name: (Last, Middle Initial, First):_____

Date of Birth: _____ Age: _____ Grade: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone number: _____ Email: _____

Referral Information: Were you referred? Yes: _____ No: _____ If referred, by whom?

_____

Payment Information: Please indicate how you intend to pay for treatment:

Cash: ___ Check: ___ Credit Card: ____ Insurance: _____ Third-Party: _____

If you are planning to use health insurance, please provide the following information:

Name of Insurance Company: _____

Subscriber's Name: _____

Insured's ID number: _____ Group Policy Number: _____

Co-Payment Amount: _____

Insurance Claim's Mailing Address: _____

Phone number: _____

Previous Mental Health Treatment History:

Have you and/or your child participated in therapy in the past? Yes: ____ No: ____

If Yes, please complete the information below:

Name and Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):

_____

Phone Number: _____ Email: _____

Street Address: _____ City: _____ State: _____

Dates of treatment: _____

Focus of treatment: _____

Name and Type of Provider (Psychiatrist, Psychologist, Therapist, or Other:

_____

Phone Number: _____ Email: _____

Street Address: _____City: _____ State: _____

Dates of treatment: _____

Name and Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):

_____

Phone Number: _____ Email: _____

Street Address: _____City: _____ State: _____

Dates of treatment: _____

Focus of treatment: _____

Has your child ever been hospitalized because of a mental health issue? Yes: _____ No: _____

If yes, please describe the reason for hospitalization:

_____
_____
_____
_____

How long was his/her hospitalization?

_____

Where was he/she hospitalized?

_____

What treatment did he/she receive during hospitalization?

_____
_____

Please provide the name of the providers who treated him/her below and indicate the type of provider (i.e., Psychiatrist, Psychologist, MD, Therapist):

Name: _____

Phone Number: _____ Email: _____

Street Address: _____City: _____ State: _____

Dates of treatment: _____

Name: _____

Phone Number: _____ Email: _____

Street Address: _____ _____City: _____ State: _____

Dates of treatment: _____

Name: _____

Phone Number: _____ Email: _____

Street Address: _____ City: _____ State: _____

Dates of treatment: _____

Current Mental Health Treatment: Are you or your child currently participating in therapy or counseling?

Yes: ____ No: _____

If yes, please complete the following information:

Name of Current Provider: _____

Type of provider: _____

Phone Number: _____ Email: _____

Street Address: _____ City: _____ State: _____

Dates of Treatment: _____

Focus of Treatment: _____

Name of Current Provider: _____

Type of Provider: _____

Phone Number: _____Email: _____

Street Address: _____ _____City: _____ State: _____

Dates of Treatment: _____

Focus of Treatment: _____

If you or your child are currently receiving therapeutic services from another psychotherapist, to avoid a duplication of services, it may be necessary for me to contact your current psychotherapist to coordinate care. You may be required to sign and "Authorization for Release of Confidential Information" form, which will be provided to you and maintained as part of your child's clinical record along with a copy of this patient intake form.

* Please Initial: _____

If your child is currently under the care of a psychiatrist, is he/she taking any prescribed psychiatric medication(s)? Yes ____ No____

If yes, please list the type of medication, the specific medication he/she has been prescribed, the dosage, and any side effects in the space below. For example: "Stimulant (type), Adderall (specific medication), 25mg twice per day (dose), Stomach upset (side effect)," or "Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect)."

_____
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Medical Treatment Information:

Is your child currently receiving treatment for a serious or chronic medical condition?

Yes: ____ No: ____

If yes, please provide the following information:

Current medical condition: _____

How long has he/she had the condition? _____

If he/she is currently taking prescribed medications for the condition, please describe the type of medication, indicate how long he/she has been taking the medication, and any side-effects he/she has experienced.

_____
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Describe current concerns, issues, or problems that you hope to resolve. Do you have specific goals for your child's therapy? (Feel free to attach additional pages, as needed.)

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Additional Information: Please let me know, in the space provided, of anything that was not addressed in this intake and anything that you would like me to know about you, your child, or any recent significant life events (Feel free to attach extra pages, as needed):

_____
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_____

Signature of Parent/Guardian: _____

Date: _____