RIVER VALLEY COUNSELING, LLC

CHILD/ADOLESCENT INTAKE PACKET

Counselor seeing:_____

CLIENT INFORMATION

Client Name _____

Street Address _____ PO Box _____

City/State/Zip _____

Home Phone # _____ **Can we leave a message at this number?** ❑ Yes ❑ No

Daytime Phone # _____ **Can we contact you here?** ❑ Yes ❑ No

Cell Phone # _____ **Can we leave a message on this phone?** ❑ Yes ❑ No

Client Date of Birth _____ Social Security # _____

Parent/Responsible Party Name (if client is minor)_____

Parent/Responsible Party Social Security # _____ Date of Birth_____

Primary Care Physician _____

Emergency Contact Name (required): _____ Phone #:_____

Address (required):_____

Insurance Information **(Copy of Insurance Card and Driver's License is required)**

• This section must be completed in full •

1) Primary Insurance Company _____Ins Co Phone # _____

Employer of Subscriber _____

Name of Subscriber _____Date of Birth _____

Subscribers Social Security # _____ Relationship to Client_____

Address of Subscriber (if different from Client) _____

2) Secondary Insurance Company _____ Ins. Co Phone # _____

Employer Name (with address) _____

Name of Subscriber _____Date of Birth _____

Subscribers Social Security # _____ _____Relationship to Client _____

Address of Subscriber (if different from Client) _____

IF THERE IS A THIRD INS. PLEASE NOTIFY RECEPTIONIST TO GIVE YOU AN ATTACHMENT

CLIENT AGREEMENT

The above information is current and correct to the best of my knowledge.

I understand the terms of my insurance coverage noted above and that I am responsible for paying the co-pay, if required, and/or the amount not covered by the terms of my insurance policy.

This agreement also grants authorization to RVC to release such information as may be necessary for completion of any insurance claim with payment of benefits to RVC for services rendered. It also confirms that I have the legal ability to seek counseling for the child/adolescent listed above.

_____ _____ _____

Client/Guardian Name (please print) Client/Guardian Signature Date

_____ _____

Witness Date

Revised 02/2015

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to the child, leave them blank.

Information supplied by: _____ Relationship: _____ Today's Date: _____

Identifying Information		
Child's Name:_____	**Date of Birth:** _____	**Age:**_____
Gender: ❑ Male ❑Female	**Race:** _____ **Height:** _____	**Weight:**_____
Hair Color:_____	**Eye Color:** _____	

Behavioral Health
Why is the child coming to counseling?
What do issues or circumstances do you believe contribute to the child's problems?
How long has this problem persisted?
Under what conditions do the problems usually get worse?
Under what conditions do the problems usually improve?
Has the child previously been involved in counseling? ❑No ❑ Yes **If yes, describe the reasons for counseling, who provided the counseling and the outcome.** **Counselor** _____ **Reason:** **Outcome:**
List your Child's greatest strengths:
List your child's greatest weaknesses:
List your child's main difficulties at home:
List your child's main difficulties at school:

Psychiatric Hospitalizations: ❑**None** ❑**Past** ❑**Current**

Dates of Service:	**# of Days**	**Where & Reason (suicidal, depressed etc.)**
Dates of Service:	**# of Days**	**Where & Reason (suicidal, depressed etc.)**

CLIENT NAME: _____ DOB: ____/____/____

Drug and Alcohol History

Indicate the level of use for each substance by checking the appropriate box.

	No Use	Past use	Current Use		No Use	Past use	Current Use
Alcohol	❑	❑	❑	**Hallucinogens**	❑	❑	❑
Marijuana	❑	❑	❑	**Inhalants**	❑	❑	❑
Hashish	❑	❑	❑	**Cocaine**	❑	❑	❑
Stimulants	❑	❑	❑	**Heroin**	❑	❑	❑
Sedatives	❑	❑	❑	**Other**: _____	❑	❑	❑

If current or past use is indicated to any of the above items complete the following questions?

Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method
					❑Oral ❑Smoked ❑Nasal ❑Injection
					❑Oral ❑Smoked ❑Nasal ❑Injection
					❑Oral ❑Smoked ❑Nasal ❑Injection

Has the child ever received inpatient drug and/or alcohol treatment? ❑ No ❑ Yes

If yes, When? _____ **Where?** _____

Has the child ever received outpatient drug and/or alcohol treatment? ❑ No ❑ Yes

If yes, When? _____ **Where?** _____

Is the child currently pregnant ? ❑ No ❑ Yes **Is the child an IV drug user?** ❑ No ❑ Yes

Family History

Parent's marital status: ❑ Married ❑ Divorced ❑ Separated ❑ Never Married ❑ Widowed

If the parents are not married, the child's age when divorce, separation or parents death occurred? _____

What is the relationship between the child and his/her custodial parent(s) Check all that apply:

❑Parents married, together ❑Single Parent, Mother ❑Single Parent Father ❑ Parents Unmarried
❑Mother & Stepfather ❑Father & Stepmother ❑Adoptive Family
❑Other _____

Living Situation: ❑ Parent's Home ❑Foster Home ❑ Relative's Home ❑Homeless ❑Group Home
❑Residential ❑ Other _____

Household members Names (if client lives in more than one household list household 1 – 2)	Relation to the Client	Age	Race	Occupation or School	Level of Education

Significant Family Members/Others not listed above:	Relation to the Client	Age	Race	Occupation or School	Level of Education

Mother's age: _____ If deceased, how old was the child when she passed away? _____

Father's age: _____ If deceased, how old was the child when he passed away? _____

Number of Brothers _____ Their ages: _____ _____ _____ _____ _____

Number of Sisters _____ Their ages _____ _____ _____ _____ _____

Where is the child in birth order (i.e. 1st born, 2nd born etc.) of his/her siblings? _____

CLIENT NAME: _____ DOB: ____/____/____

Briefly describe the style of parenting, including types of discipline, used in the household.

Describe the reasons your child is disciplined.

Parent's Employment

Mother's Current Employment Status ❑Employed ❑Unemployed Job/Occupation:_____

Name of employer: _____ Date Last Worked_____ Satisfied with Job ❑Yes ❑No

Father's Current Employment Status ❑Employed ❑Unemployed Job/Occupation:_____

Name of employer: _____ Date Last Worked_____ Satisfied with Job ❑Yes ❑No

Financial Problems ❑ No ❑Yes If yes, explain: _____

Developmental History

List any drugs/medications used by the mother or family at the time of conception or by the mother during pregnancy

Indicate important physical development issues including developmental milestones including sensory/motor, motor, cognitive, mental retardation or autism

List the ages when the following developmental milestones occurred:

	Age	**Comments**
Walking	_____	_____
Talking	_____	_____
Toilet Trained	_____	_____

Rate your child's development, compared to others the same age in he following areas

Social Development	❑Below Average	❑Average	❑Above Average
Physical Development	❑Below Average	❑Average	❑Above Average
Language	❑Below Average	❑Average	❑Above Average
Intellectual Ability	❑Below Average	❑Average	❑Above Average
Emotional Expression	❑Below Average	❑Average	❑Above Average

For each type of development that you rated as *Below Average*, describe your current *Specific* areas of concern.

Medical History

Physician Name: _____

Address: _____
Street & Number City State Zip

Date of most recent physical exam: _____ **By Whom:** _____ **Phone:** _____

Results: _____

Immunizations Check the immunizations for the following diseases:

❑ Chicken Pox ❑Diphtheria ❑ German Measles ❑Measles ❑Mumps
❑Polio ❑ Small Pox ❑Tetanus

CLIENT NAME: ____ **DOB:** ____/____/____

***Drug Allergies:**

List any major illness and/or operations

Has the child had any medical hospitalizations in the last three years ❑ No ❑ Yes, if yes, complete below:

Hospital	City	Date	Reason

List any *current* physical concerns (e.g. high blood pressure, headaches, dizziness, etc.):

List any *past* physical concerns:

Has the child ever had head trauma that resulted in loss of consciousness and/or required medical treatment? ❑ No ❑ Yes

What medications is client now taking? *List all medications including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.*

Prescription/Over the Counter Medication: ❑No ❑ Yes	**Out of Medication:** ❑ No ❑ Yes
Current Medication: ________________ **Total Daily Dosage:** ________________ **Reason:** ________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** ________________ **Total Daily Dosage:** ________________ **Reason:** ________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown
Current Medication: ________________ **Total Daily Dosage:** ________________ **Reason:** ________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** ________________ **Total Daily Dosage:** ________________ **Reason:** ________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown
Current Medication: ________________ **Total Daily Dosage:** ________________ **Reason:** ________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** ________________ **Total Daily Dosage:** ________________ **Reason:** ________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown

Does the client/family think medications help the client get better? ❑ N/A ❑ No ❑ Yes ❑ Unknown

Does your child use caffeine? ❑ No ❑ Yes from (coffee, tea, soda)________________ Daily Use__________
Does your child use tobacco? ❑ No ❑ Yes from (cigarettes, snuff, snus) ________________ Daily Use__________

On the average, how many hours of sleep does your child receive nightly? ________________

After going to bed, how long does it take your child to fall asleep? ________________

If falling asleep is a problem, how long has it been a problem? ________________

Does your child regularly awaken in the night? ❑ No ❑Yes

Does your child regularly have bad dreams or nightmares? ❑ No ❑Yes

Does your child experience bad dreams and is unable to awaken during them? ❑ No ❑Yes

Describe your child's appetite? ❑ Poor Appetite ❑Average Appetite ❑Large Appetite
Has the child's weight changed in the last year? ❑ **No** ❑**Yes** **If yes, by how much?** __________ ❑ **weight gain** ❑**loss**

Has client had any of the following symptoms in the past 60 days? ***Please check.***

❑ Bedwetting	❑ Coughing	❑ Lightheadedness	❑ Sleep Problems
❑ Blood in Stool	❑ Diarrhea	❑ Memory Problems	❑ Seizures
❑ Breathing Difficulty	❑ Dizziness	❑ Muscle Weakness	❑ Tingling in Arms/Leg
❑ Confusion	❑ Falling	❑ Nervousness	❑ Tremors
❑ Consciousness Loss	❑ Gait Unsteadiness	❑ Panic Attacks	❑ Vision Changes
❑ Constipation	❑ Hearing Loss	❑ Pulse Irregularity	❑ Vomiting

❑ Other: ____

CLIENT NAME: _____ **DOB:** ____/____/____

Educational History

School: _____

Highest Academic Year completed:_____ **Highest Vocational Year Completed: (if applicable)**_____

Type of school placement: ❑ Regular ❑ Special Education ❑Home-Schooled ❑Unknown

Type of Special Education Placement: ❑ None ❑Cognitive Disability ❑Emotional Disability
❑Learning Disability ❑Multiple Disabilities
❑Other: _____

Does your child experience any of the following problems (check all that apply)**:**
❑ Poor Attendance ❑Poor Grades ❑Suspension/Expulsion

Has your child ever been retained in a grade? ❑ No ❑ Yes **If yes, which grade(s):** _____

Has your child passed the school's proficiency tests? ❑Yes ❑No ❑ Does not apply

Does your child have special communication needs? ❑ TTD Device ❑Interpreter Services

Legal History and Children Services Involvement

Legal Guardian(s)/Custodians	**Phones**

Current Legal Status ❑None ❑On Probation ❑Detention ❑On Parole ❑Awaiting Charges
❑Other _____

Convictions

Incarcerations

Probation/Parole Officer (if applicable):	**Phone:**

Juvenile Court Involvement (for Child Abuse, Neglect or Dependency)
Current ❑No ❑Yes
Past ❑No ❑Yes

Family Court Ordered into Counseling ❑No ❑Yes

Juvenile Court Case worker (if applicable):	**Phone:**

Civil Court Proceedings:

Domestic Relations Court Involvement (i.e. Custody, Protective Services, Restraining Order):

Child Support Enforcement Orders:

Children's Protective Services Involvement with Family: ❑No ❑Yes

Name of GAL/CASA assigned to family (if applicable):	**Phone:**
Name of Children Services Caseworker assigned to the family (if applicable):	**Phone:**

_____ _____ _____
Print Name (Person completing questionnaire): **Signature:** **Date:**

Staff only

_____ _____ _____
Reviewer Name/Degree (if applicable) **Signature:** **Date:**