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

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

Client Date of Birth _____ Social Security # _____

Primary Care Physician _____

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

Emergency Contact Name (required):_____Phone #:_____

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:**_____

Behavioral Health

Why is the child coming to counseling?

How long has this problem persisted?

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 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.)**

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: _____

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**

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? _____

***Drug Allergies:**

List any major illness and/or operations

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

Prescription/Over the Counter 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

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 <u>symptoms in the past 60 days</u>? *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

❑ Additional Information: _____

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

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:**