West Des Moines
CENTER FOR PSYCHOTHERAPY

ADOLESCENT INTAKE FORM

FOR OFFICE USE ONLY	
Client File No:	Today's Date:
Payment Method:	
Closing Date:	

DEMOGRAPHIC INFORMATION

First Name:	Middle:	Last Name:	
Date of Birth [mm/dd/yyyy]:	Age:	Gender: ☐ Male ☐ Female	Ethnicity:
E-Mail: ______________________ Can we e-mail you at this address? ☐ Yes ☐ No		Please note that email is not a secure form of communication and therefore your privacy and confidentiality cannot be guaranteed.	
Home Address:	City:	Zip:	

FAMILY INFORMATION

Guardianship Information

With whom do you live at this time?

Your parents relationship status is: ☐ Single ☐ Cohabitating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Who has your legal custody?

- ☐ Biological Mother
- ☐ Biological Mother and Father
- ☐ Biological Father & Step-Parent
- ☐ Foster Parents
- ☐ Biological Father
- ☐ Biological Mother & Step-Parent
- ☐ Adoptive Parents
- ☐ Family Member: ______________________

Parent 1 Demographic Information

First Name:	Middle:	Last Name:
Date of Birth [mm/dd/yyyy]:	Age:	Ethnicity:
Is this parent currently employed: ☐ Full Time ☐ Part Time ☐ Unemployed		Level of Education:
Employer:		Occupation:
Home Phone: ______________ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No	Cell Phone: ______________ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No	Work Phone: ______________ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No

Parent 2 Demographic Information

First Name:	Middle:	Last Name:
Date of Birth [mm/dd/yyyy]:	Age:	Ethnicity:
Is this parent currently employed: ☐ Full Time ☐ Part Time ☐ Unemployed		Level of Education:
Employer:		Occupation:
Home Phone: ______________ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No	Cell Phone: ______________ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No	Work Phone: ______________ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No

Sibling(s) and Others Who Live in Household (If Applicable): If there are more than two members, use the back of this form.		
First Name:	Middle:	Last Name:
Date of Birth [mm/dd/yyyy]:	Age:	Gender: ☐ Male ☐ Female
What is your relationship with this person? ☐ Sibling ☐ Other: ___		
First Name:	Middle:	Last Name:
Date of Birth [mm/dd/yyyy]:	Age:	Gender: ☐ Male ☐ Female
What is your relationship with this person? ☐ Sibling ☐ Other: ___		

EMERGENCY CONTACT INFORMATION

First Name:	Middle:	Last Name:
Address:	City:	Zip:
Home Phone:	Cell Phone:	Work Phone:
What is your relationship to this individual?		

REFERRAL INFORMATION

Were you referred to us? ☐ Yes ☐ No	If yes, who referred you?

If no, how did you hear about us?

☐ Website ☐ Psychology Today ☐ Medical Doctor
☐ Local Magazine ☐ Yellow Pages ☐ Other: ___

SUBSTANCE USE INFORMATION

Do you use or have a problem with alcohol or drugs? ☐ Yes ☐ No

If yes, please describe briefly: ___

___

MEDICAL INFORMATION

Primary Care Physician (PCP)		
Name:	Physician's Phone:	
Address:	City:	Zip:

Psychological History			
Have you received previous counseling? ☐ Yes ☐ No	If yes, who was your provider?		
Address:	City:	State:	Zip:
Provider's Phone:	Diagnosis:		
Did you find counseling beneficial? ☐ Very Beneficial ☐ Beneficial ☐ Somewhat Beneficial ☐ Not Beneficial			

Psychiatric History

Have you received psychiatric help? ☐ Yes ☐ No ☐ Current | Psychiatrist's Name:

Address: | City: | State: | Zip:

Psychiatrist's Phone: | Diagnosis:

Have you ever been hospitalized as a result of this diagnosis? ☐ Yes ☐ No If yes, when? __________________ [mm/dd/yyyy]

Has your psychiatrist prescribed medication? | Dosage:

Did you find your psychiatric care beneficial? ☐ Very Beneficial ☐ Beneficial ☐ Somewhat Beneficial ☐ Not Beneficial

Health History

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any vision problems? ☐ Yes ☐ No ☐ Contacts ☐ Glasses | Do you have any hearing difficulties? ☐ Yes ☐ No

Do you have any serious medical conditions? ☐ Yes ☐ No

If yes, please describe: ______________________________

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please describe: ______________________________

Do you have any allergies? ☐ Yes ☐ No

If yes, please describe: ______________________________

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please describe: ______________________________

Please place a check mark besides each medical issue you have had. Check all that apply.

☐ Asthma
☐ Bronchitis
☐ Cerebral Palsy
☐ Chicken Pox
☐ Croup
☐ Diabetes
☐ Diphtheria
☐ Dizziness
☐ Earaches
☐ Ear Infections
☐ Encephalitis
☐ Hay Fever
☐ Heart Trouble
☐ Hepatitis
☐ High Fevers
☐ Hives
☐ Influenza
☐ Lead Poisoning
☐ Measles
☐ Meningitis
☐ Multiple Sclerosis
☐ Mumps
☐ Muscular Dystrophy
☐ Nose Bleeds
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Severe Colds
☐ Severe Head Injury
☐ Sexually Transmitted Disease
☐ Thyroid Disorder
☐ Whooping Cough

EDUCATIONAL HISTORY

School: | Grade in School: ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐ College Freshman ☐ College Sophomore

School District:

What type of school are you currently attending? ☐ Public ☐ Private ☐ Home School ☐ Other: __________________

Teacher: | School Counselor:

Are you enrolled in special education? ☐ Yes ☐ No If yes, please explain: ______________________________

Are you enrolled in a gifted program? ☐ Yes ☐ No If yes, please explain: ______________________________

Have you ever been held back in school? ☐ Yes ☐ No If yes, please explain: ______________________________

Which school subjects do you enjoy most?	
Which school subjects do you dislike?	
Which grades do you typically receive, on average, at school? ☐ As ☐ Bs ☐ Cs ☐ Ds ☐ I am failing out of school.	
Have there been any recent changes in your grades? ☐ Yes ☐ No If yes, please explain: ______________________________	
Which school activities do you enjoy most?	
Have you received psychological testing? ☐ Yes ☐ No If yes, when? ______________________________ [mm/dd/yyyy]	
Where was this testing done?	Phone:

Who completed this form (if other than client?)

Name:	Date: _______________ [mm/dd/yyyy]
Relationship to Client:	

MAIN PRESENTING CONCERNS

Below, please list each of your main presenting concerns; approximately how long you have been affected by each; and how you would rate them using this scale.

1	2 to 3	4 to 6	7 to 9	10
Not a Problem	Mild Problem	Moderate Problem	Severe Problem	Couldn't be Worse

1.	Rating:	How long?
2.	Rating:	How long?
3.	Rating:	How long?

Presenting Problems: Which of the following apply to you currently? Please check all that apply.

- ☐ Adjustment
- ☐ Aggression
- ☐ Anger
- ☐ Alcohol Use
- ☐ Anxiety
- ☐ Bedwetting
- ☐ Blinking/Jerking
- ☐ Bullies/Threats
- ☐ Careless/Reckless
- ☐ Criminal Charges
- ☐ Defiance
- ☐ Depression
- ☐ Destructiveness
- ☐ Dizziness
- ☐ Drug Use
- ☐ Eating Disorder
- ☐ Fatigue
- ☐ Fearfulness
- ☐ Frequent Injuries
- ☐ Frustration
- ☐ Hallucinations
- ☐ Head Banging
- ☐ Hopelessness
- ☐ Hurting Animals
- ☐ Impulsiveness
- ☐ Irritability
- ☐ Learning Problems
- ☐ Lie Frequently
- ☐ Loner
- ☐ Low Self-Esteem
- ☐ Migraines
- ☐ Moodiness
- ☐ Often Sick
- ☐ Oppositional
- ☐ Over Active
- ☐ Over Weight
- ☐ Panic Attacks
- ☐ Phobias
- ☐ Physical Abuse
- ☐ Poor Appetite
- ☐ Quarrels
- ☐ Sadness
- ☐ Selfishness
- ☐ Separation Anxiety
- ☐ Setting Fires
- ☐ Sexual Abuse
- ☐ Sexually Acting Out
- ☐ Short Attention Span
- ☐ Shyness/Timid
- ☐ Sleeping Problems
- ☐ Slow Moving
- ☐ Soiling
- ☐ Speech Problems
- ☐ Stealing
- ☐ Stomach Aches
- ☐ Suicidal Behaviors
- ☐ Suicidal Plans
- ☐ Suicidal Thoughts
- ☐ Talking Back
- ☐ Teeth Grinding
- ☐ Thumb-Sucking
- ☐ Unsafe Behaviors
- ☐ Unusual Thinking
- ☐ Weight Loss
- ☐ Withdrawing
- ☐ Worrying Excessively
- ☐ Other: _______________

____

____

PAYMENT INFORMATION

1. Will you be personally responsible for paying for charges of services incurred at our office? ☐ Yes ☐ No

OR

2. Will you be paying for services incurred at our office with your insurance? ☐ Yes ☐ No

Personal Payment Information: If you answered “yes” to Question 1, please read and sign the statement below.

Your signature below represents your acknowledgement and understanding that: 1) you will be personally responsible for all charges involved in the rendering of our services; 2) payment will be due at the time of each visit unless you have made other arrangements in advance; and 3) a service fee of $100 will be charged for appointments that are not attended or cancelled without sufficient notice (we request an advanced notice of at least 48 hours) as we reserve that time to work with you.

Signature of Client: ______________________________ Date [mm/dd/yyyy]: ____________________

Insurance Information: If you answered “yes” to Question 2, please complete your insurance information below.

While your insurance or another person may be paying for all or part of our charges, our agreement is with you. Your signature below indicates your understanding and acknowledgement that: 1) you will be personally responsible for all charges involved in the rendering of our services not paid by your insurance company; 2) payment will be due at the time of each visit unless you have made other arrangements in advance; and 3) a service fee of $100 will be charged for appointments that are not attended or cancelled without sufficient notice (we request an advanced notice of at least 48 hours) as we reserve that time to work with you.

We will be filing your insurance claim for you; however, we suggest that you call your insurance company to get information regarding your co-payment and deductible before your first session. Ask them about your coverage for “outpatient mental health services” so you may determine the appropriate payment for our services.

Signature of Client: ______________________________ Date [mm/dd/yyyy]: ____________________

PRIMARY INSURANCE COMPANY:

Company Name: ______________________________

Subscriber Name: ______________________________

Subscriber Date of Birth [mm/dd/yyyy]: ______________

Subscriber SSN: ______________________________

Subscriber #: ______________ Group #: ____________

Co-Payment Amount: ______________________________

*** A COPY OF YOUR INSURANCE CARD IS REQUIRED.

SECONDARY INSURANCE COMPANY (IF APPLICABLE):

Company Name: ______________________________

Subscriber Name: ______________________________

Subscriber Date of Birth [mm/dd/yyyy]: ______________

Subscriber SSN: ______________________________

Subscriber #: ______________ Group #: ____________

Co-Payment Amount: ______________________________

*** A COPY OF YOUR INSURANCE CARD IS REQUIRED.

INSURANCE PAYMENT AUTHORIZATION:

I hereby authorize insurance payment directly to my psychologist not to exceed the balance due for regular charges. I understand that I am financially responsible to my provider for charges not covered by insurance. A photocopy of this document shall be valid as the original.

Signature of Client: ______________________________ Date [mm/dd/yyyy]: ____________________

INSURANCE RELEASE OF INFORMATION AUTHORIZATION:

I hereby authorize my psychologist to release my mental health records to my insurance company to the full extent specified under any or all federal laws and Iowa Code Chapter 228, or as subsequently amended, for the purpose of payment submission; administration of claims; to conduct utilization and quality control review; or to conduct audit of claims paid.

I acknowledge that I am aware that I may inspect the information disclosed at any time, and may revoke this authorization at any time if I furnish written revocation to my provider; thus, I agree to accept financial liability for services provided if insurance should deny claims for benefits because of the inability to examine my mental health records. A photocopy of this authorization will be valid as the original.

Signature of Client: ______________________________ Date [mm/dd/yyyy]: ____________________