West Des Moines
CENTER FOR PSYCHOTHERAPY

ADOLESCENT INTAKE FORM

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

DEMOGRAPHIC INFORMATION

First Name:	Middle:	Last Name:
Preferred Name:	Date of Birth [mm/dd/yyyy]:	Age:
Preferred Pronouns:	Race:	Ethnicity:
Gender Identity:	Sexual Orientation:	
Home Address:	City:	Zip:
Mobile Phone: ____________ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No	Home Phone: ____________ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No	Which phone do you prefer that we use to contact you? ☐ Mobile ☐ Home
E-Mail: ____________ Can we e-mail you at this address? ☐ Yes ☐ No Do you want us to e-mail you appointment reminders? ☐ Yes ☐ No	Please note that email is not a secure form of communication and therefore your privacy and confidentiality cannot be guaranteed. If you would like us to send you appointment reminders, you understand that you are authorizing us to contact you via e-mail.	

FAMILY INFORMATION

Guardianship Information

With whom do you live at this time?

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

Who has your legal custody? (Check all that apply)

☐ Natural Mother ☐ Adoptive Mother
☐ Natural Father ☐ Adoptive Father
☐ Step-Mother ☐ Foster Mother
☐ Step-Father ☐ Foster Father
☐ Other: ____________

Primary Caregiver 1 Demographic Information

First Name:	Middle:	Last Name:
Date of Birth [mm/dd/yyyy]:	Gender:	Ethnicity:
Is this caregiver 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

Primary Caregiver 2 Demographic Information

First Name:	Middle:	Last Name:
Date of Birth [mm/dd/yyyy]:	Gender:	Ethnicity:
Is this caregiver currently employed: ☐ Full-Time ☐ Part-Time ☐ Unemployed	Level of Education:	

Employer:	Occupation:

Home Phone: ______	Cell Phone: ______	Work Phone: ______
Can we call this number? ☐ Yes ☐ No	Can we call this number? ☐ Yes ☐ No	Can we call this number? ☐ Yes ☐ No
Can we leave a message? ☐ Yes ☐ No	Can we leave a message? ☐ Yes ☐ No	Can we leave a message? ☐ Yes ☐ No

Others Living in the Home (Siblings, step-siblings, grandparent, etc.): If more than three members, use the back of this page.

First Name:	Middle:	Last Name:
Date of Birth [mm/dd/yyyy]:	Gender:	Ethnicity:

What is your relationship with this person? ☐ Sibling ☐ Other: ______

How good is the relationship between you and this person?

First Name:	Middle:	Last Name:
Date of Birth [mm/dd/yyyy]:	Gender:	Ethnicity:

What is your relationship with this person? ☐ Sibling ☐ Other: ______

How good is the relationship between you and this person?

First Name:	Middle:	Last Name:
Date of Birth [mm/dd/yyyy]:	Gender:	Ethnicity:

What is your relationship with this person? ☐ Sibling ☐ Other: ______

How good is the relationship between you and this person?

Protective Services

Has a member of the family been involved with a report to Department of Human Services? ☐ Yes ☐ No

If yes, please indicate date of report [mm/dd/yyyy]: ______

Which individual(s) in the household was involved in the report? ______

Is this report still under investigation? ☐ Yes ☐ No

If there have been additional reports made to the Department of Human Services, please list here:

______

______

______

EMERGENCY CONTACT INFORMATION

Please be sure to provide a local contact and all their information so we can easily reach your emergency contact. Providing this information does not constitute a release of information. If you would like this person to have access to your records, your guardian will need to give us permission to do so. This person will only be contacted under instances specified by HIPAA.

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

DEVELOPMENTAL HISTORY

Birth Mother

Duration of Pregnancy: ___________ weeks.	Complications:

During pregnancy, did birth mother…

Smoke	☐ Yes	☐ No	If so, average number of cigarettes per day: ________________
Drink alcohol	☐ Yes	☐ No	If so, average number of drinks per day: ________________
Use illegal drugs	☐ Yes	☐ No	If so, specify drugs and usage: ________________
Use prescription medication	☐ Yes	☐ No	If so, specify medications and usage: ________________

Labor & Delivery

Type of Delivery (Check all that apply): ☐ Normal ☐ Induced ☐ Breech ☐ Forceps ☐ Caesarian

Birth Weight: __________ lbs. __________ oz.	Length: _________ inches.	Apgar Score (If known): _________

Any complications during labor or delivery?

Post-Delivery

Respiration	☐ Immediate	☐ Delayed	If delayed, for how long?
Cry	☐ Immediate	☐ Delayed	If delayed, for how long?
Infection	☐ Yes	☐ No	If so, what was it?

Total number of days that you were in the hospital after delivery?

Infancy & Early Childhood

With regards to these milestones, at what rate did you develop?

Speaking Words	☐ Slow	☐ Average	☐ Fast	☐ Difficulty: ________________
Speaking Sentences	☐ Slow	☐ Average	☐ Fast	☐ Difficulty: ________________
Crawling	☐ Slow	☐ Average	☐ Fast	☐ Difficulty: ________________
Walking	☐ Slow	☐ Average	☐ Fast	☐ Difficulty: ________________
Feeding Self	☐ Slow	☐ Average	☐ Fast	☐ Difficulty: ________________
Toilet Training	☐ Slow	☐ Average	☐ Fast	☐ Difficulty: ________________
Tying Shoes	☐ Slow	☐ Average	☐ Fast	☐ Difficulty: ________________

Did you need to receive support from a professional for any of the above? ________________

____

Developmental Trauma

Have you ever had a head injury? ☐ Yes ☐ No	If so, did you lose consciousness? ☐ Yes ☐ No
If you lost consciousness, for how long?	Have there been multiple head injuries? ☐ Yes ☐ No

If so, when?

Have you been involved in an accident or any other physically traumatic experience? ☐ Yes ☐ No

Have you experienced emotional trauma? ☐ Yes ☐ No

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? ☐ Yes ☐ No | Are you currently taking this medication? ☐ Yes ☐ No

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 | Do you have any hearing difficulties? ☐ Yes ☐ No

Date of last vision test: [mm/dd/yyyy] | Do you wear? ☐ Contacts ☐ Glasses | Why?

Date of last hearing test: [mm/dd/yyyy] | Were the results normal? ☐ Yes ☐ No

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

If yes, please describe: ____

Have you ever been taken to the emergency room for a serious emergency, illness, or surgery since birth? ☐ Yes ☐ No

If yes, please describe condition, injury, and dates of treatment: ____

____

Do you have a chronic illness or disability? ☐ Yes ☐ No

If yes, please describe along with any adaptive equipment or devices used on a regular basis: ____________________

____

How well do you sleep? ☐ Excellent ☐ Good ☐ Fair ☐ Poor | Do you: ☐ have nightmares ☐ sleep-walk

Describe any nighttime issues:

Please check all that apply:

Condition		
Learning Disability	☐ Mother Side	☐ Father Side
ADHD	☐ Mother Side	☐ Father Side
Speech/Language Difficulty	☐ Mother Side	☐ Father Side
Emotional/Behavioral Problems	☐ Mother Side	☐ Father Side
Genetic Problems	☐ Mother Side	☐ Father Side
Diabetes	☐ Mother Side	☐ Father Side
Hypertension (Blood Pressure)	☐ Mother Side	☐ Father Side
Cancer	☐ Mother Side	☐ Father Side
Headaches	☐ Mother Side	☐ Father Side
Seizures	☐ Mother Side	☐ Father Side
Heart Disease/High Cholesterol	☐ Mother Side	☐ Father Side
Other: ____________________	☐ Mother Side	☐ Father Side

EDUCATIONAL HISTORY

Current Educational Level		
School:		Grade in School: ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐ College Freshman ☐ College Sophomore
School District or College:		
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: ____________		
If you are in special education, do you have any: ☐ Individualized Education Plan (IEP) or ☐ 504 Plan		
Are you enrolled in a gifted program? ☐ Yes ☐ No If yes, please explain: ____________		
How would you rate your overall intelligence compared to your peers? ☐ Above Average ☐ Average ☐ Below Average		
Have you ever repeated a grade in school? ☐ Yes ☐ No If yes, please explain: ____________		
Which school subjects do you enjoy most?		
Which school subjects do you dislike?		
Are you receiving tutoring for a specific subject? ☐ Yes ☐ No	Which?	
Which extra-curricular activities do you enjoy most?		
Which grades do you typically receive, on average, at school? ☐ As ☐ Bs ☐ Cs ☐ Ds ☐ I am failing out of school.		
Have you received psychological, educational, or neuropsychological testing? ☐ Yes ☐ No When? ________ [mm/dd/yyyy]		
Where was this testing done?		Phone:
How do you approach school work? (Mark an "x" where you believe you fall in each continuum to the right.)	Organized ------------------------|------------------------ Disorganized Meticulous ------------------------|------------------------ Sloppy Responsible ------------------------|------------------------ Procrastinator Cooperative ------------------------|------------------------ Refuse to Complete Timely ------------------------|------------------------ Late Dedicated ------------------------|------------------------ No Effort	

Social Development	
How would you describe your social skills?	
Have you ever been bullied? ☐ Yes ☐ No	Have you bullied others? ☐ Yes ☐ No
How would you describe your peer relationships?	☐ Difficulty making friends. ☐ Difficulty maintaining friendships. ☐ Easily make friends. ☐ Make long-term friendships. ☐ Other: ____________
Describe any unusual, traumatic, or possibly stressful event in your life that you think may have had an impact on your development or current functioning. Include the incident and age at the time of the incident: ____________	

ADDICTIVE & RISK BEHAVIORS

Addiction Potential	
Do you use caffeine? ☐ Yes ☐ No	What and how much do you consume?

Do you use nicotine? ☐ Yes ☐ No	What and how much do you consume?
Do you use alcohol? ☐ Yes ☐ No	What and how much do you consume?
Do you use illicit drugs? ☐ Yes ☐ No	What and how much do you consume?
How much time do you spend on a daily basis on video games and/or social media?	

Risk Behaviors

Are you sexually active? ☐ Yes ☐ No	Are you using any form of birth control? ☐ Yes ☐ No	Any concerns? ☐ Yes ☐ No
Do you have any suicidal intentions? ☐ Yes ☐ No	Do you have any aggressive intentions? ☐ Yes ☐ No	
Have you engaged in any self-harm behaviors? ☐ Yes ☐ No	What?	

Have you ever been arrested or involved in any criminal activity? ____________________

____

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?
4.	Rating:	How long?
5.	Rating:	How long?

Symptom Checklist: Please review the following list and check all that apply.

☐ Headaches/Migraines
☐ Loss of Consciousness
☐ Dizziness
☐ Blurred Vision
☐ Hearing Problems
☐ Mood Swings
☐ Depression
☐ Irritability
☐ Aggression
☐ Anxiety

☐ Attention Problems
☐ Disorganized
☐ Hyperactive/Impulsive
☐ Poor Concentration
☐ Often Interrupts Others
☐ Sensitivity to Noise
☐ Sensitivity to Light
☐ Chronic Pain
☐ Get Lost Frequently
☐ Clumsy/Poor Motor Skills

☐ Feelings of Worthlessness
☐ Difficulty Making Decisions
☐ Social Withdrawal
☐ Personality Change
☐ Little or No Interest in Peers
☐ Overreact to Touch
☐ Auditory Hallucinations
☐ Visual Hallucinations
☐ Motor or Vocal Tics
☐ Incoherent Speech

REFERRAL INFORMATION

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

If no, how did you hear about us?

☐ Website
☐ School Counselor
☐ Psychology Today
☐ Yellow Pages
☐ Medical Doctor
☐ Other: ____________________

Who completed this form (if other than client)?

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

PAYMENT INFORMATION

Will you be paying **out-of-pocket** for the services received at the West Des Moines Center for Psychotherapy?

☐ Yes ☐ No

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.

____

Parent/Guardian Signature

Will you be paying for services incurred at our office with your **insurance**?

☐ Yes ☐ No

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 to get information regarding your coverage before your first session.

____

Parent/Guardian Signature

INSURANCE PAYMENT AUTHORIZATION:
I hereby authorize insurance payment directly to my psychology provider 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.

Parent/Guardian Signature: ______________________________ 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 am aware that I may inspect the information disclosed and may revoke this authorization at any time if I furnish written revocation to my mental health 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.

Parent/Guardian Signature: ______________________________ Date [mm/dd/yyyy]: ____________________