West Des Moines
CENTER FOR PSYCHOTHERAPY

CHILD 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: |
| Gender Identity: | Race: | Ethnicity: | |
| Home Address: | City: | Zip: | |

## FAMILY INFORMATION

**Guardianship Information**

With whom does your child live at this time?

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

Who has the child's 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: _____ | 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 |

**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 the child's relationship with this person? ☐ Sibling ☐ Other: _____ | | |
| How good is the relationship between the child and this person? | | |
| First Name: | Middle: | Last Name: |
| Date of Birth [mm/dd/yyyy]: | Gender: | Ethnicity: |
| What is the child's relationship with this person? ☐ Sibling ☐ Other: _____ | | |
| How good is the relationship between the child and this person? | | |
| First Name: | Middle: | Last Name: |
| Date of Birth [mm/dd/yyyy]: | Gender: | Ethnicity: |
| What is the child's relationship with this person? ☐ Sibling ☐ Other: _____ | | |
| How good is the relationship between the child 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 the emergency contact. Providing this information does not constitute a release of information. If you would like this person to have access to the child's records, a 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 the child's relationship to this individual? | | |

## DEVELOPMENTAL HISTORY

**Birth Mother**

| | |
|---|---|
| Duration of Pregnancy: _____ weeks. | Complications: |

During pregnancy, did the 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 the child was in the hospital after delivery? | | | |

**Infancy & Early Childhood**

With regards to these milestones, at what rate did the child 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 the child need to receive support from a professional for any of the above? _____

_____

| Developmental Trauma | |
|---|---|
| Has the child ever had a head injury? ☐ Yes ☐ No | If so, did they lose consciousness? ☐ Yes ☐ No |
| If the child lost consciousness, for how long? | Have there been multiple head injuries? ☐ Yes ☐ No |
| If so, when? | |
| Has the child been involved in an accident or any other physically traumatic experience? ☐ Yes ☐ No | |
| Has the child experienced emotional trauma? ☐ Yes ☐ No | |

## MEDICAL INFORMATION

| Pediatrician | | |
|---|---|---|
| Name: | Physician's Phone: | |
| Address: | City: | Zip: |

| Psychological History | | | |
|---|---|---|---|
| Has the child received previous counseling? ☐ Yes ☐ No | If yes, who was their provider? | | |
| Address: | City: | State: | Zip: |
| Provider's Phone: | Diagnosis: | | |
| Did they find counseling beneficial? ☐ Very Beneficial ☐ Beneficial ☐ Somewhat Beneficial ☐ Not Beneficial | | | |

| Psychiatric History | |
|---|---|
| Has the child received psychiatric help? ☐ Yes ☐ No ☐ Current | Psychiatrist's Name: |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| Psychiatrist's Phone: | Diagnosis: | | |

Has the child ever been hospitalized as a result of this diagnosis? ☐ Yes ☐ No If yes, when? _____ [mm/dd/yyyy]

| Has the psychiatrist prescribed medication? ☐ Yes ☐ No | Is the child currently taking this medication? ☐ Yes ☐ No |
|---|---|

Did the child find the psychiatric care beneficial? ☐ Very Beneficial ☐ Beneficial ☐ Somewhat Beneficial ☐ Not Beneficial

## Health History

How would you rate the child's overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

| Does the child have any vision problems? ☐ Yes ☐ No | Does the child have any hearing difficulties? ☐ Yes ☐ No |
|---|---|

| Date of last vision test: [mm/dd/yyyy] | Does child wear? ☐ Contacts ☐ Glasses | Why? |
|---|---|---|

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

Does the child have any serious medical conditions? ☐ Yes ☐ No

If yes, please describe: _____

Has the child 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: _____

_____

Does the child 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 does child sleep? ☐ Excellent ☐ Good ☐ Fair ☐ Poor | Do they: ☐ have nightmares ☐ sleep-walk |
|---|---|

Describe any nighttime issues:

Please check all that apply:

| | | |
|---|---|---|
| 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: ☐ TK ☐ K ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 5th ☐ 8th |
|---|---|
| School District: | |

What type of school is child currently attending? ☐ Public ☐ Private ☐ Home School ☐ Other: _____

| Teacher: | School Counselor: |
|---|---|

Is the child enrolled in special education? ☐ Yes ☐ No If yes, please explain: _____

If enrolled in special education, does the child have any: ☐ Individualized Education Plan (IEP) or ☐ 504 Plan

Is the child enrolled in a gifted program? ☐ Yes ☐ No If yes, please explain: _____

How would you rate the child's overall intelligence compared to their peers? ☐ Above Average ☐ Average ☐ Below Average

Has the child ever repeated a grade in school? ☐ Yes ☐ No If yes, please explain: _____

Which school subjects does the child enjoy most?

Which school subjects does the child dislike?

Is the child receiving tutoring for a specific subject? ☐ Yes ☐ No | Which?

Which extra-curricular activities does the child enjoy most?

Which grades does the child typically receive, on average, at school? ☐ As ☐ Bs ☐ Cs ☐ Ds ☐ Child failing out of school.

Has child received psychological, educational, or neuropsychological testing? ☐ Yes ☐ No When? _____ [mm/dd/yyyy]

Where was this testing done? | Phone:

How does the child approach school work? (Mark an "x" where you believe the child falls 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 the child's social skills?

Has the child ever been bullied? ☐ Yes ☐ No | Has the child bullied others? ☐ Yes ☐ No

How would you describe the child's 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 the child's life that you think may have had an impact on their development or current functioning. Include the incident and age at the time of the incident: _____
_____

## ADDICTIVE & RISK BEHAVIORS

**Addiction Potential**

| | |
|---|---|
| Does child use caffeine? ☐ Yes ☐ No | What and how much does child consume? |
| Does child use nicotine? ☐ Yes ☐ No | What and how much does child consume? |
| Does child use alcohol? ☐ Yes ☐ No | What and how much does child consume? |
| Does child use illicit drugs? ☐ Yes ☐ No | What and how much does child consume? |

How much time does child spend on a daily basis on video games and/or social media?

**Risk Behaviors**

| | |
|---|---|
| Is child sexually active? ☐ Yes ☐ No | Do you talk with the child about their sexual development? ☐ Yes ☐ No |
| Does child have any suicidal intentions? ☐ Yes ☐ No | Does child have any aggressive intentions? ☐ Yes ☐ No |

| Has child engaged in any self-harm behaviors? ☐ Yes ☐ No | What? |
|---|---|
| Has child ever been arrested or involved in any criminal activity? _____ _____ | |

## MAIN PRESENTING CONCERNS

Below, please list the child's main presenting concerns; approximately how long they 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 to the child.

☐ 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?<br><br>☐ Yes ☐ No<br><br>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.<br><br>_____<br>Parent/Guardian Signature | Will you be paying for services incurred at our office with your **insurance**?<br><br>☐ Yes ☐ No<br><br>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.<br><br>_____<br>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]: _____