ADOLESCENT INTAKE INFORMATION – Page 1

(To be completed by parent or guardian & adolescent)

IDENTIFYING INFORMATION

Adolescent's Name: _____ Today's Date_____

Gender: ☐ M ☐ F Age: _____ Birth Date:_____ Social Security Number:_____

Custodial parent(s), adoptive/foster, or guardian's name: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Parent's Work:_____ Parent's Work: _____

May we leave messages for you at home? ☐ Yes ☐ No May we leave messages for you at work? ☐ Yes ☐ No

Grade in School: _____ School: _____ Phone: _____

Referred by: _____

Others Living in Home (name, birth date, relationship to client): _____

_____

_____

Immediate family living outside the home (name, birth date, relationship to client): _____

_____

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION

Name of Insured: _____ Insured Date of Birth:_____

Address of Insured:_____ City, State, Zip: _____

Relationship of Client to Insured: _____ Employer of Insured:_____

Insurance Company:_____ Phone: _____

Insurance Company Address: _____ City, State, Zip:_____

Insurance Identification Number: _____ Group Number: _____

Secondary insurance: _____ Phone: _____

Name of Secondary Insured: _____ Insured Date of Birth:_____

Secondary Company Address: _____ City, State, Zip:_____

Secondary Identification Number: _____ Group Number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

_____ Date:_____

FOR OFFICE USE ONLY
DIAGNOSIS:

ADOLESCENT INTAKE INFORMATION – Page 2

(To be completed by parent or guardian & adolescent)

Family Information:

Biological parents/adoptive/foster parents/guardians: _____

Significant others: _____

DHS involvement? ___Yes ____ No If yes who is the case worker?_

Main Source of Household income _____wages/ Salary _____General Assistance

_____other _____none

Please list all individuals supported by the above income, even if they do not currently reside in the household:

Name	Age	Relationship to Child	Currently residing with client?

Medical History

Birth and early childhood impairments:_____
_____

Attainment of developmental milestones:_____
_____

Chronic illness and/or physical conditions

Past:_____
_____
_____

Present:_____
_____
_____

Medications (Type of medication, dosages and response to medication)

Past:_____
_____
_____

Present:_____
_____
_____

Psychiatrist or Psychiatric Nurse Practitioner:_____

Phone: _____ Address: _____

Your adolescent's pediatrician or primary care physician (PCP): _____

Phone: _____ Address: _____

ADOLESCENT INTAKE INFORMATION – Page 3
(To be completed by parent or guardian & adolescent)

Date of last physical: _____

Please describe your adolescent's nutritional habits:
_____
_____
_____

Mental Health History

Has the client or anyone in your family ever received counseling? ___Yes ____No

Has anyone in the family ever received medication or been hospitalized for mental health reasons? ____ Yes ____ No

Has anyone in the family threatened or attempted suicide? _____Yes ____ No

Has a family member's drug or alcohol use caused problems in the family?

_____Yes _____ No

Educational History:

Adolescent's academic level is
___ Above grade level
___ At grade level
___ Below grade level
___ Much below grade level

In school the client has: ___No Behavioral problems ___ Frequent Behavioral problems _____ Some Behavioral problems

Has the client been in special education classes ___ Yes ____No

Behavioral History:

If your adolescent has ever been sexually, physically, or emotionally/verbally abused , please describe:
_____
_____
_____

Has your adolescent ever:
____ Been cruel to animals
____ Set fires
____ Discussed plans to commit suicide
____ Tried to hurt themselves

Has your adolescent ever witnessed domestic violence? ____ Yes ____No

Has your adolescent ever experienced the loss or death of a significant family member?
____ Yes ____No

Does your adolescent have difficulty making or keeping friends? ____ Yes ____No

Additional information:

What is the client's ethnic/cultural background and spiritual or religious background?_____

INTAKE INFORMATION – Page 4

(To be completed by parent or guardian & adolescent)

What are the family strengths?

_____
_____
_____

What are your adolescent's interests and strengths?

_____
_____
_____

Why are you bringing your adolescent to therapy?

_____
_____
_____

Paula Levinrad provides services to all clients who are eligible regardless of race, color, religion, national origin, sex, age, marital status, disability, or other factors prohibitive by law or regulation.

I authorize billing to my insurance company and payment of medical benefits directly to Paula Levinrad. I authorize Paula Levinrad to provide information to my insurance company that is necessary to complete this billing process.

I agree to provide at least 24 hours notice of cancellation of an appointment

Signature of Client or Guardian _____ Date_____