Intake Information

Our Family:

(if child spends time living in two homes, please fill out this page for each household)

Child we are seeking services for:	Date of Birth:
Parent(s) or guardian(s)	Phone Numbers (check preferred)
	home ☐
	cell ☐
	other ☐
E-mail Address	prefer messages to be left by ☐ phone ☐ email ☐ text
Street Address	City, State and Zip Code
Other children or family members in the home	Relationship to child in services (age)

Insurance Information:

(if you have secondary insurance, please fill out this page for both policies)

Primary Insurance Company:	Policy Holder Name/Date of Birth:
Child's Policy ID Number:	Child's Policy Group ID Number:
Co-pay/coinsurance per visit $_____	Insurance Company Address:
Insurance Company Phone:	

Insurance companies vary in the confidential information they require in order to pay for services. In addition to information regarding diagnosis and dates of service, some insurance providers will request treatment plans, progress reports, or session notes.

Your signature below indicates that you have read and understood all of the above material and consent to have Tracy LeBlanc, LICSW, CMHS release your confidential information as needed to collect payment from your insurance.

_____

Parent/Guardian Signature Date

Medical Information:

Child's Primary Care Doctor:	Phone Number:
Other Medical providers that prescribe or provide services to your child	Phone Number:
Please list all medications and over the counter medications or supplements your child takes	Dosage Prescriber

Current Concerns and Hopes for Counseling:

1. What are the struggles or problems that your child or family are experiencing that you are seeking help with?

2. What strategies have you already tried to address these struggles and in what ways have these been helpful?

3. What are your primary goals for counseling for both your child and your family?

4. Every parent has strengths that help him/her deal with difficult and challenging situations. Please describe your strengths as a parent.

5. Please describe your child's strengths:

6. Are there any religious, spiritual and/or cultural issues that are important to your child/family?
□ Yes □ No If yes, please explain:

Family Information

7. Is there any family history that you think contributes to the struggles or strengths that you bring with you to counseling at this time?

8. Please describe any strengths or struggles in the relationships between family members that impact the issues that you are seeking counseling for today.

School History

School: Grade:
Teacher:

9. Has your child:

Yes	No	
□	□	Received Special Education services?
□	□	Been suspended/expelled? (If yes, please circle appropriate choice)
□	□	Received academic honors?
□	□	Attended multiple schools?
□	□	Been afraid to attend school?
□	□	Had other difficulties in school? If yes, please explain:

Trauma History

10. Has your child ever experienced or witnessed:

Yes	No	Don't know		Yes	No	Don't know	
☐	☐	☐	Homelessness	☐	☐	☐	Physical abuse
☐	☐	☐	Domestic violence	☐	☐	☐	Sexual abuse
☐	☐	☐	Neglect	☐	☐	☐	community violence
☐	☐	☐	death of loved one	☐	☐	☐	other:

Behavior History

11. Has your child had problems with:

Yes	No		Yes	No	
☐	☐	Running away	☐	☐	Vandalism
☐	☐	Stealing	☐	☐	Bathroom issues
☐	☐	Fire setting	☐	☐	Being cruel to animals
☐	☐	Aggression	☐	☐	Sexually acting out

Substance Abuse History

12. Does your child:

Yes	No	Don't know		Yes	No	Don't know	
☐	☐	☐	Use any drugs	☐	☐	☐	smoke cigarettes

13. If yes, has he/she received any treatment?
    ☐ Yes ☐ No ☐ Don't know

Has anyone else in the family struggled with drug or alcohol abuse or addiction?
☐ Yes ☐ No If yes, please explain:

Mental Health History

14. Has your child had any counseling in the past?
    ☐ Yes ☐ No
    If yes, where?

    How long did your child receive these services? What diagnosis (if any) was given?

    How helpful were these services?
    ☐ Not helpful at all ☐ Somewhat helpful
    ☐ Helpful ☐ Very helpful

Has anyone else in your family:

Yes	No	
☐	☐	Received counseling?
☐	☐	Been hospitalized for psychological/psychiatric reasons?

If yes, who?

15. In general, please describe your child's mood:
    - ☐ Mostly in a positive mood
    - ☐ Mostly angry or irritable
    - ☐ Mostly sad or depressed
    - ☐ Mostly anxious or on edge
    - ☐ Mostly hyper/out of control

16. Please estimate the effect the current problem has on your child's functioning in the following areas:

	None	Mild	Moderate		Severe
Family	☐	☐	☐	☐	☐
School	☐	☐	☐	☐	☐
Peer relationships	☐	☐	☐	☐	☐
Physical well-being	☐	☐	☐	☐	☐

Safety Issues

17. Has your child ever:

Yes	No	Don't know	
☐	☐	☐	Tried to seriously harm him/herself
☐	☐	☐	Made statements about wanting to die
☐	☐	☐	Attempted suicide
☐	☐	☐	Threatened to harm others
☐	☐	☐	Purposefully hurt another

If yes to any of the above, please explain?

18. Does your child have access to:

Yes	No	Don't know	
☐	☐	☐	Guns/ammunition
☐	☐	☐	Medications
☐	☐	☐	Knives/other weapons
☐	☐	☐	Explosives
☐	☐	☐	The Internet
☐	☐	☐	Do you have guns/weapons in your home?
☐	☐	☐	Do you have ammunition in your home?

19. Please describe any safety concerns you have about your child:

Other

20. How will you know when services are no longer needed? What will you notice you and your child doing differently that is not being done now?

21. Please tell me anything else you think I need to know about you and your child in order to understand your situation.