HERITAGE
FAMILY COUNSELING SERVICES

6525 E Mainsgate Rd
Wichita, KS 67226
(316) 461-7923
fax 260-7045

# CHILD/YOUTH INTAKE FORM

**NAME:** _____ _____ _____
First Name Middle Initial Last Name

**DOB:** _____ **AGE:** _____ **SS NUMBER:** _____ **GENDER:** ☐ Male ☐ Female

**ADDRESS:** _____ **APT.#:** _____

**CITY:** _____ **STATE**: _____ **ZIP**: _____

**PHONE NUMBER:** _____ _____ _____
Home Cell Work

**E-MAIL ADDRESS:** _____

**PLEASE LIST ALL PERSONS (INCLUDING YOURSELF) CURRENTLY LIVING IN YOUR HOUSEHOLD.**

| | NAME | RELATIONSHIP | DOB | AGE | OCCUPATION/YEARS OF EDUCATION |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |

**WHO IS LEGALLY AUTHORIZED TO RECEIVE INFORMATION ABOUT AND MAKE DECISIONS REGARDING THIS CHILD'S CARE?**

| NAME | RELATIONSHIP | PHONE NUMBER |
|---|---|---|
| | | |
| NAME | RELATIONSHIP | PHONE NUMBER |

**DESCRIBE YOUR FAMILY, CULTURE AND RELIGIOUS CONNNECTIONS:** _____

**WHO REFERRED YOU TO US:** _____

**WHAT PROBLEMS BRING YOU TO SEEK TREATMENT:** _____

**IS TREATMENT COURT ORDERED?** ☐ Yes ☐ No

**SOCIAL, PLAY AND RECREATION:** **Describe your child's social play and recreational interests:** _____

**LAST GRADE LEVEL ACHIEVED:** _____

## DEVELOPMENTAL HISTORY:

**PREGNANCY:** ☐ FULL TERM ☐ PREMATURE ☐ LATE **DELIVERY:** ☐ NORMAL DELIVERY ☐ C-SECTION

Problems during pregnancy: _____

MILESTONES: Walking: _____Months Talking: ____Months Toilet Trained: ____Months

## PARENTING TIME ARRANGEMENTS: ☐ YES ☐ NO

If applicable please provide a copy of any current court orders regarding the parenting time plan.

## CHILD/FAMILY MENTAL HEALTH HISTORY: (Please mark each that apply with "1" for child, "2" for immediate family, and "3" for extended family.)

| | | | |
|---|---|---|---|
| _____ INDIVIDUAL THERAPY | _____ MARITAL THERAPY | _____ FAMILY THERAPY | _____ SEX THERAPY |
| _____ DOMESTIC VIOLENCE | _____ ANGER MANAGEMENT | _____ GROUP THERAPY | _____ GRIEF |
| _____ LOSS | _____ ANXIETY | _____ DEPRESSION | _____ ADHD |
| _____ SEXUAL ABUSE | _____ PHYSICAL ABUSE | _____ BIPOLAR DISORDER | _____ EATING DISORDER |
| _____ PSYCHIATRIC HOSPITALIZATIONS | _____ SCHIZOPHRENIA | _____ ANTISOCIAL BEHAVIOR (HISTORY OF VIOLATING THE LAW) | _____ DRUG USE |
| _____ ALCOHOL USE | _____ OTHER SUBSTANCES_____ | _____ OTHER ADDICTIONS_____ | |

## FAMILY MEDICAL HISTORY: (Please mark each that apply with "1" for child, "2" for immediate family, and "3" for extended family.)

| | | | |
|---|---|---|---|
| _____ ASTHMA | _____ HIGH BLOOD PRESSURE | _____ KIDNEY DISEASE | _____ DENTAL PROBLEMS |
| _____ CANCER | _____ THYROID PROBLEMS | _____ LIVER DISEASE | _____ TUBERCULOSIS |
| _____ DIABETES | _____ SEASONAL ALLERGIES | _____ HEART DISEASE | _____ HEAD INJURY |
| _____ HEARING ISSUES | _____ SEIZURES | _____ ALLERGIES | _____ OTHER |

## CURRENTLY PRESCRIBED MEDICATIONS AND PRESCRIBING PHYSICIAN:

_____

## CURRENT GENERAL FUNCTIONING: (Please mark each that apply.)

| | | |
|---|---|---|
| _____ CHEERFUL/HAPPY MOOD MOST OF THE TIME | _____ SAD OR TEARFUL MOST OF THE TIME | _____ FEELINGS OF HOPELESSNESS/ EMPTINESS |
| _____ WITHDRAWN BEHAVIORS/ ISOLATION | _____ DIFFICULTY CONCENTRATING | _____ UNDER ACTIVE/SLUGGISH BEHAVIOR |
| _____ DECREASE IN INTERESTS/ACTIVITIES | _____ FEELINGS OF GUILT | _____ DOWN MOST DAYS |
| _____ DECREASED APPETITE | _____ INCREASED APPETITE | _____ WEIGHT GAIN |
| _____ WEIGHT LOSS | _____ NO ENERGY | _____ OVERLY FATIGUED DURING THE DAY |
| _____ SUICIDAL THOUGHTS | _____ SUICIDE ATTEMPTS | _____ INTENTIONAL SELF-HARM (I.E. CUTTING) |
| _____ POOR SELF-CARE/POOR HYGIENE | _____ POOR MEMORY | _____ EXTREME UPS AND DOWNS IN MOOD |
| _____ WORRY | _____ PANIC | _____ AVOIDANT |
| _____ STRESS | _____ IRRITABILITY | _____ ANGER |
| _____ TAKES MORE THAN AN HOUR TO FALL ASLEEP | _____ NIGHT WAKING FOR LONGER THAN 30 MINUTES | _____ HARD TO WAKE UP IN THE MORNING |

| | | |
|---|---|---|
| _____ UNABLE TO SLEEP IN OWN BED THROUGH THE NIGHT | _____ FEARFUL OF PLACES, SITUATIONS OR PEOPLE | _____ FAST/RAPID SPEECH FEEL RESTED AFTER 3-4 HOURS SLEEP |
| _____ FEARLESS/ENGAGING IN RECKLESS ACTIVITIES | _____ EXAGGERATED VIEW OF ABILITIES | _____ LYING |
| _____ THREAT TO HURT SOMEONE WITH INTENT /PLAN | _____ PHYSICAL AGGRESSION | _____ CONFLICT WITH AUTHORITY FIGURES |
| _____ STEALING | _____ PHYSICAL CRUELTY TO ANIMALS | _____ PROPERTY DAMAGE |
| _____ VERBAL THREATS TO HARM OTHERS | _____ THOUGHTS OF HARM TO OTHERS | _____ INABILITY TO REMAIN SEATED |
| _____ EXPLOSIVE OUTBURSTS | _____ DISTINCT PERIODS OF NONSTOP ACTIVITY | _____ POOR SOCIAL SKILLS |
| _____ LEGAL PROBLEMS | _____ EXTREME CONFLICT WITH OTHERS | _____ GRADIOSITY-UNREALISTIC SENSE OF SUPERIORITY |
| _____ PROBLEMS WITH SCHOOL PERFORMANCE | _____ INABILITY TO COMPLETE TASKS | _____ INABILITY TO SUSTAIN ATTENTION |
| _____ EASILY DISTRACTED | _____ OVERACTIVE/HYPERACTIVE | _____ IMPULSIVITY |
| _____ COMPULSIONS | _____ DENIAL | _____ NIGHTMARES |
| _____ SLEEPWALKING | _____ WETTING ACCIDENTS | _____ SEXUAL INAPPROPRIATE TOUCHING OF OTHERS |
| _____ SEXUAL PLAY WITH TOYS OR OBJECTS | _____ EXCESSIVE MASTURBATION | _____ PROBLEMS WITH RELATIONSHIPS |
| _____ JEALOUSY | _____ EXTREME CONFLICT WITH SIBLINGS | _____ BLENDED FAMILY |
| _____ DIVORCE | _____ FAMILY CONFLICT | _____ TRUST |
| _____ SHAME | _____ CRISIS | _____ CONCERNS WITH CHILD CARE |
| _____ DISABILITY | _____ EMPLOYMENT | _____ INTENTIONAL PURGING |
| _____ INTENTIONAL VOMITING | _____ HOARDING FOOD | _____ BINGE EATING |
| _____ ANOREXIA | _____ BULIMIA | _____ OBESITY |
| _____ BODY IMAGE | _____ SELF-ESTEEM | |

## AUTHORIZATION AND CONSENT TO TREAT A MINOR

**By signing below you are authorizing Heritage Family Counseling Services to provide your child with mental health services. I acknowledge that both natural parents even though divorced may have a right to obtain from Heritage Family Counseling Services information regarding the nature and course of treatment of the child named above. In instances of divorce, it is essential that the legal custodian of the child grant permission for the services. If you are a divorced parent, stepparent, grandparent, guardian or other, you are required to provide a copy of the court order which names you legal custodian of the above named child. (MUST BE SIGNED BEFORE SERVICES CAN BE PROVIDED)**

**Parent/Guardian Signature X** _____ **Date**_____

**Parent/Guardian Signature X** _____ **Date**_____

**Child/Youth Signature X**_____ **Date**_____

**BILLING INFORMATION** *If billing information is not complete and accurate, we reserve the right to **NOT** schedule additional appointments until it is supplied.*

**PAYMENT OPTION:** ☐ INSURANCE ☐ SELF-PAY ☐ OTHER _____

**PRIMARY INSURANCE POLICY INFORMATION**

Primary Insurance Company: _____

Insurance Member I.D. Number: _____ Insurance Group Number (or none): _____

Effective Date: _____

**PRIMARY INSURANCE INSURED PERSON INFORMATION**

Client's relationship to insured (i.e. self, spouse, child, other): _____

Insured Name: _____

Insured's Street Address: _____

Insured's City: _____ Insured's State: _____ Insured's Zip Code: _____

Insured's Phone Number: _____

Insured's Date of Birth: _____ Insured's Gender: ☐ Male ☐ Female

Insured's Employer: _____

**By signing this agreement below you agree to and acknowledge each of the following conditions.**

1. The information provided regarding insurance coverage is accurate.
2. Payment for any and all required co-payments, deductibles, coinsurance and non-allowable charges is required and due at the time the service is delivered. Payment must be in the form of cash, check or credit cards.
3. If your insurance company denies, refuses, or fails to make payments for the services rendered, Heritage Family Counseling Services will notify you in writing.
4. You assume responsibility for any and all fee's rendered associated with services including document preparation fees provided at Heritage Family Counseling Services.
5. You will be solely responsible for the full cost of the session if you do not show up for your appointment or do not cancel at least 24 hours in advance.
6. Insufficient fund checks will be assessed a $30.00 charge.
7. You are responsible for notifying Heritage Family Counseling Services of any changes in name, address, telephone number or insurance coverage.
8. By signing this agreement, you agree to allow Heritage Family Counseling Services to release any and all information necessary for filing insurance claims and collecting fees from your insurance company.
9. Heritage Family Counseling Services shall have the authority to charge and assess collection costs and expenses, including reasonable attorney's fees, and penalties and interest for the late payment or nonpayment thereof.

Print Name_____ Date _____

Parent/Guardian Signature X _____