COUNSELING NEW PATIENT INTAKE

Two options for completing this form:

- Please fill out on your computer, print it, and bring it to your first appointment.
- Please print out this form, then fill it out using a pen, and bring it to your first appointment.

Note: Regardless of the completion method selected above, signatures on page 8 & 9 require you to use a pen to complete them. If you email us the form, this can be done in our office.

FUNCTIONAL KIDS THERAPY
every child deserves a champion

PATIENT CONTACT INFORMATION

Child's Name:_____ Nickname:_____ DOB:_____: Age: _____

M/F:_____ Current Diagnosis: _____

Address:_____ Apt (if applicable) _____

City:_____ State:_____ Zip Code: _____

Primary Phone:_____ Preferred E-mail: _____

Child's School:_____ Grade: _____

Parent/Guardian Contact Information

Parent #1 Name:_____ DOB:_____ Occupation: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

SSN: _____ Marital Status: M S W D (please circle one)

Parent #2 Name:_____ DOB:_____ Occupation: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

SSN: _____ Marital Status: M S W D (please circle one)

Emergency Contact:_____ Relationship:_____ Phone: _____

Primary Language:_____ Language(s) spoken at home: _____

Child's Primary Physician:_____ Address and Phone: _____

PRIMARY AREAS OF CONCERN

What are your goals for counseling? Please be as general or as specific as you would like. We will refine these goals as part of our first meeting and revisit them throughout to meet your child's individualized needs.

GESTATIONAL HISTORY

Full Term: ☐ Yes ☐ No	Premature: ☐ Yes ☐ No If yes, how many weeks?____
Low Birth Weight: ☐ Yes ☐ No _____lb(s)_____oz	Breech Birth: ☐ Yes ☐ No
Type of delivery: ☐ Vaginal ☐ C-section ☐ Emergency	Forceps Assisted: ☐ Yes ☐ No
Vacuum Assisted: ☐ Yes ☐ No	Preeclampsia: ☐ Yes ☐ No
Gestational Diabetes: ☐ Yes ☐ No	Multiple Ultrasounds: ☐ Yes ☐ No
Oxygen Deprivation: ☐ Yes ☐ No	NICU Stay: ☐ Yes ☐ No If yes, how many weeks?____

Please list any other significant prenatal or birth history (exposure to substances, complications, etc):

_____

_____

DEVELOPMENTAL AND MEDICAL HISTORY

Sat up:	☐ On Time	☐ Delayed	Rolled Over:	☐ On Time	☐ Delayed
Pulled to Stand:	☐ On Time	☐ Delayed	Belly Crawled:	☐ On Time	☐ Delayed
Hands & Knees Crawled:	☐ On Time	☐ Delayed	Walked:	☐ On Time	☐ Delayed
Spoke First Word:	☐ On Time	☐ Delayed	Spoke First Sentence:	☐ On Time	☐ Delayed

My child communicates using: ☐ Non-verbal ☐ Single words ☐ 2-3 word phrases ☐ Sentences

Bladder Control

Accidents at night? ☐ Yes ☐ No If yes, how often?_____
Accidents during the day? ☐ Yes ☐ No If yes, how often?_____

Bowel Control

Accidents at night? ☐ Yes ☐ No If yes, how often?_____
Accidents during the day? ☐ Yes ☐ No If yes, how often?_____

Has your child's physical development been normal? ☐ Yes ☐ No

If no, please explain:

_____

_____

Please list any other chronic conditions/history including illnesses, hospitalizations, or surgeries:

_____

_____

MEDICATIONS

Is your child currently on any medications? If so please list the medications below.

Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____

Has any medication been effective? Please explain: _____

_____

_____

THERAPEUTIC HISTORY

Has your child had any previous counseling, occupational, physical, and/or speech therapy service? If yes, please list:

_____

_____

_____

Has your child ever had any mental health treatment? ☐ Yes ☐ No
If so, please indicate which type and age/date at the time of treatment:

- Psychological Testing:_____ Age_____ Date _____
- Individual/Group/Family Therapy:_____ Age_____Date _____
- Psychiatric Hospitalization:_____ Age_____Date _____
- Residential Treatment:_____ Age_____Date _____

Please provide any additional details regarding these services:

_____

_____

ACADEMIC HISTORY

Please check any that may apply:

☐ Oppositional ☐ Disrupt Class ☐ Inattentive ☐ Refuse to go to school
☐ Detention ☐ Disorganized ☐ School suspension ☐ Fail to turn in work regularly

Has your child ever had problems with their learning ability? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Have instructional modifications been attempted? ☐ Yes ☐ No
If yes, please explain:_____

_____

_____

Has your child ever completed educational testing? ☐ Yes ☐ No
If yes, please explain:_____

_____

_____

Summarize your child's progress (eg. Experience, Academics, Social Skills) within each of the following grade levels.

Preschool:_____
Kindergarten:_____
Grades 1-3:_____
Grades 4-6:_____
Middle School/JR High:_____
High School:_____

Please briefly summarize your child's academic strengths:_____

Please briefly summarize your child's academic weaknesses:_____

SOCIAL HISTORY

Check the most appropriate answer:

1. How does your child get along with their sibling(s)?
   ☐ Better than average ☐ Average ☐ Worse than Average ☐ Doesn't have any
2. How easily does your child make friends?
   ☐ Better than average ☐ Average ☐ Worse than Average
3. How many close friends does your child have?
   ☐ None ☐ 1-2 Friends ☐ 3-5 Friends ☐ 5+ Friends
4. On average, how long does your child keep friends?
   ☐ Less than 6 months ☐ 6-12 months ☐ 2 years+
5. Describe your child socially:
   ☐ Withdrawn ☐ Insecure ☐ Outgoing ☐ Passive
   ☐ Oppositional ☐ Aggressive ☐ Other:_____

What extra-curricular activities is your child involved in?

What responsibilities does your child have at home?

Has your child ever had any legal difficulties: ☐ Yes ☐ No If yes, please explain:

Are you aware of any alcohol, tobacco and/or other drug use by your child? ☐ Yes ☐ No If yes, please explain:

BEHAVIORAL AND SOCIAL CHECKLIST *(please check any that apply within last 6 months)*

- ☐ Excessive crying
- ☐ Decreased Energy
- ☐ Feelings of being worthless
- ☐ Thoughts of suicide
- ☐ Feeling overwhelmed
- ☐ Trouble making decisions
- ☐ Avoids going places
- ☐ Isolating self from others
- ☐ Afraid of being judged/ rejected
- ☐ Sensitive to criticism
- ☐ Self-harm or cutting
- ☐ Apathetic, doesn't seem to care
- ☐ Needs things to be perfect
- ☐ Excessive anxiety about separation
- ☐ Obsessive behaviors or thoughts
- ☐ Abruptly changing moods
- ☐ Angry, easily irritated
- ☐ Difficulty controlling temper
- ☐ Skin picking, hair pulling, nail biting
- ☐ Inflexible, trouble handling change
- ☐ Difficulties with sleep
- ☐ Concerns related to life change
- ☐ Memory problems
- ☐ Attention problems
- ☐ Full of energy, little need for sleep
- ☐ Talking fast and excessively
- ☐ Impulsive acts without thinking
- ☐ Can't sit still, antsy
- ☐ Always on the go, hyper
- ☐ Problems following the rules
- ☐ Difficulty with authority
- ☐ Unmotivated, procrastinating
- ☐ Trust issues
- ☐ Abusive towards others
- ☐ Feeling overly important
- ☐ Feels bullied/ picked on
- ☐ Few or no friends
- ☐ Considered "weird" by others
- ☐ Problems with boundaries
- ☐ Problems in relationships with parents
- ☐ Problems with friends, siblings, roommates
- ☐ Threatens or bullies others
- ☐ LGBTQ+
- ☐ Abused or neglected by others
- ☐ Lying, stealing
- ☐ Avoid conflict
- ☐ History of traumatic experiences
- ☐ Hoarding food or objects
- ☐ Poor body image
- ☐ Financial concerns
- ☐ Sexual concerns
- ☐ Suspicious, paranoid
- ☐ Hearing or seeing things others do not

Other: _____

_____

_____

_____

FAMILY MEDICAL HISTORY

Check if there is any history of any of the following in the family. If yes, please list the family member (eg. Mother, grandfather, sibling etc.)

☐ Learning Disabilities_____ ☐ ADHD_____ ☐ ASD_____
☐ Depression_____ ☐ Anxiety_____ ☐ Tics or Tourettes_____
☐ Diabetes_____ ☐ Arrests_____ ☐ Alcohol or Drug Abuse_____
☐ Psychosis or Schizophrenia_____ ☐ Suicide Attempts or Suicide_____

HOME ENVIRONMENT

Who has legal custody of your child? _____

Primary living situation for the past year:

Both parent's home ☐ Relative's home ☐ One parent's home ☐
Friends home ☐ Legal guardian's home ☐ Other ☐

Please describe the family home: ☐ House ☐ Apartment ☐ Condo ☐ Trailer (mobile home/RV camper)

Please indicate who sleeps in each room:

_____

_____

Please describe your neighborhood:

_____

_____

Who has taken care of the child most of their life?_____

Who is the primary disciplinarian in the family? _____

Are they: ☐ Strict ☐ Lenient

Do the parents usually agree on the issues of parenting, rules and discipline?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely

Do the parents get along with each other?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely

What strategies have been used to address problems? (check those that apply and circle those that have been successful)

☐ Verbal Reprimands ☐ Time out ☐ Removal of privileges ☐ Rewards
☐ Physical Punishments ☐ Giving in to the child ☐ Avoiding the child ☐ Other

On the average, what percentage of the time does your child comply with initial commands?

0-20% ☐ 20-40% ☐ 50% ☐ 60-80% ☐ 80-100% ☐

On the average, what percentage of the time does your child eventually comply with commands?

0-20% ☐ 20-40% ☐ 50% ☐ 60-80% ☐ 80-100% ☐

Have there been any major stressors or changes in the family home where the child was raised? ☐ Yes ☐ No

Yes If yes, check all that apply:

	Past	Current (6 months or less)		Past	Current (6 months or less)
Financial problems	☐	☐	Separation from Sibling(s)	☐	☐
Frequent Moves	☐	☐	Mental Illness in Family	☐	☐
Job Changes	☐	☐	Physical Illness in Family	☐	☐
Drinking/Drug Problems	☐	☐	Psychiatric Hospitalization of Parent	☐	☐
Arguments between Parents	☐	☐	Death in the Family	☐	☐
Separation between Parents	☐	☐	Incestuous Behavior in Family	☐	☐
Remarriage of Parent(s)	☐	☐	Other: _____		

What are the family's strengths?

_____

_____

_____

What are the family's challenges?

_____

_____

_____

What are the child's strengths/challenges?

_____

_____

_____

How has the family been changed by the child's difficulties?

_____

_____

_____

What does the family see as their role in treatment? Which family members are willing and able to participate?

_____

_____

_____

Is there anything else about this child or family that we should know in order to be more helpful?

_____

_____

_____

** please bring this form, as well as psychological or educational test results, report cards, behavior modification charts and any other pertinent documents to your next appointment**

RELIGIOUS/FAITH HISTORY

What is your family's religious/faith background:

_____

_____

_____

Does your child attend a place of worship? ☐ Yes. If yes, where? _____ ☐ No

Please list anything (positive or negative) that is important and may have affected your child in regard to faith:

_____

_____

_____

PATIENT INFORMATION AND INFORMED CONSENT TO TREAT

Thank you for choosing Functional Kids Therapy for your counseling needs. We are committed to giving you the best care possible. To familiarize you with the policies and procedures of our clinic, we are providing the following information.

Emergencies: In case of an AFTER-HOURS emergency, go to the nearest emergency room. Functional Kids Therapy does not have an emergency number.

Confidentiality: Your patient records are the property of Functional Kids Therapy LLC and shall be treated as confidential, to insure quality record maintenance and patient confidentiality. Functional Kids Therapy LLC will conduct routine patient record audits. To comply with state and federal laws regarding confidentiality your records will not be released without written consent. Everything about your care will be held in the strictest confidence (with the exception of situations which we are required by law to report: such as suspected or reported child abuse, etc.). If you choose to have your Functional Kids Therapy LLC providers(s) keep a third party informed of your progress in counseling, it will be necessary to complete a "Release of Information" form that will be kept on file.

Non-Voluntary Discharge from Treatment: A patient may be terminated from Functional Kids Therapy LLC non- voluntarily, if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment/ payment arrangements in a timely manner. The patient will be notified of the non-voluntary discharge by letter. The patient may appeal this decision with the Functional Kids Therapy Clinic Director or request to reapply for services at a later date.

Consent and Acknowledgement:
I have read and understood the information above. I give my consent for the patient named above to receive tutoring services from the tutor or tutoring organization named in this form.
Parent/Guardian Signature (if minor): _____
Relationship to Patient: _____ Date: _____

FUNCTIONAL KIDS PARENT/GUARDIAN CONDUCT POLICY

By signing below all parents and guardians are agreeing to adhere to the Functional Kids Conduct Policy which prohibits the use of any and all negative behaviors to intimidate, harass, belittle, or threaten staff members in this place of business. Any violations with the above mentioned behaviors are grounds for immediate dismissal from Tutoring Services. Be advised that any extreme situation experienced by a staff member can be immediately reported to the local authorities and your care will be immediately terminated from our practice without verbal or written advanced warning.

Parent/Guardian Signature: _____ Date: _____

DIVORCE/LEGAL SEPARATION COLLECTION POLICY

It is the policy of Functional Kids Therapy LLC that the parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. You will be responsible for payment of the child/adolescent's treatment regardless of any financial arrangement for payment for medical care, either oral or written, with the child/adolescent's other parent or responsible party. Functional Kids Therapy LLC assumes NO responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for your child/adolescent's medical care.

Parent/Guardian Signature:_____Date: _____

FUNCTIONAL KIDS INSURANCE POLICY

You are responsible for knowing your benefits outlined in your specific insurance plan including your co-insurance, co-pay, and deductible amounts if applicable. Please be advised that many insurance providers do not cover therapy due to most developmental disorders. **Functional Kids Therapy Center LLC** is NOT responsible for these costs that are dictated by your insurance carrier and if coverage is denied you will be responsible for payment of care, including any evaluations.

Should you be delinquent in paying your bill past 3 months and have not made arrangements for a payment schedule, you are legally responsible for the amount outlined by your insurance carrier and will be sent to collections if the account goes unpaid. You are responsible for any finance charges & fees **Functional Kids Therapy Center LLC** incurs in collecting therapy service fees from you including legal costs for actions that may be needed to collect on you account(s).

My signature below is confirmation that I have been informed of and agree to the insurance policy of Functional Kids Therapy Center LLC.

Insurance Information:

Primary Insurance: _____
Subscriber:_____
Subscriber date of birth: _____
Relationship:_____
Contract/ID#_____
Group#_____
Employer: _____

Secondary Insurance :_____
Subscriber:_____
Subscriber date of birth: _____
Relationship:_____
Contract /ID# _____
Group#_____
Employer: _____

I,_____, hereby give my consent for **Functional Kids Therapy Center LLC** to bill my/my child's insurance carrier for the services rendered to me/my child/family by the above-mentioned provider. In addition, I agree to pay **Functional Kids Therapy Center LLC** deductibles or uncovered charges in accordance with my health care plan.

Parent/Guardian Signature _____

Relationship to client _____

Date _____

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

I consent to the use of electronic communication to contact me as needed. I understand that my service provider may charge me for such communication and also that electronic communication, while very convenient, may not always be secure.

I authorize to be contacted via text-message at _____

I authorize to be contacted via electronic mail at _____

☐I prefer to be only contacted via US Mail and telephone number on file.