Samaritan Center, Inc.

Child/Adolescent Client Intake Information

Thank you for choosing Samaritan Center for your care. Please complete the following forms entirely. This information will aid your provider in your care.

Child/Adolescent Information

First Name _____ Middle Initial_____ Last Name _____

Birth Date _____ Age_____ Gender _____M _____F Soc Sec # _____

Address _____ City/State _____ Zip _____

Phone _____ Grade____ School_____

Ethnicity ____ African American ____ Asian ____ Caucasian ____ Hispanic/Latino(a)

____Native-American ____ Other: _____

Parent/Guardian Information

First Name _____ Middle Initial_____ Last Name _____

Mailing Address (if different from above)_____ City St. Zip_____

I am client's ___ Mother ___ Father ____Guardian I am client's Custodial Parent ___Yes ___No

I am authorized to seek medical treatment for this client. ___Yes ___No

I have brought court documents as proof of standing with court (If child is part of a legal proceeding including custody agreement) ___Yes ___No

(Per Texas State Board of Examiners of Professional Counselors Title 22, Texas Administrative Code Chapter 681 a licensed therapist "shall obtain and review a current copy of the custody agreement or court order as well as any applicable divorce degree" and "shall maintain these documents in the client's record" prior to conducting any therapy services)

Which phone number is best to use in order to contact you and leave a message?

Cell Phone _____ May we leave messages on this phone? Y N

Work Phone _____ May we leave messages on this phone? Y N

Home Phone _____ May we leave messages on this phone? Y N

Email Address_____

Emergency Contact:

Name _____ Relationship to the minor_____ Phone_____

Primary Care Physician _____ Phone _____

Please complete the following information required by our grant funding:

Have you served in the military ____ Active Duty ____ Veteran ____ Family Member ____ No

Annual Household Income $_____ Number living in your household_____

Insurance Information (Please provide a copy of your current card and picture ID at 1st appointment)

Primary Insurance Co._____ Member ID# _____ Group# _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Social Sec. # _____

Secondary Insurance Co. _____ Member ID# _____ Group# _____

Primary Insurance Co._____ Member ID# _____ Group# _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Social Sec. # _____

Financially Responsible Party (Complete if NOT self, client is a minor, or the main policy holder

First Name _____ Middle Initial_____ Last Name _____

Birth Date _____ Soc Sec # _____ Relationship to client _____

Address _____ City/State _____ Zip _____

Phone _____

Preferred Pharmacy

Pharmacy Name _____ Phone _____

Address _____

Insured or Responsible Party Signature: I consent and authorize Samaritan Center to release medical or other supporting information necessary to process my insurance claims and/or for the collection of payment for services from the above person/organization/company. I authorize payments of medical benefits to the Samaritan Center. However, I understand I am responsible for all deductibles and co-pays. I understand that I will be responsible for 100% of my charges should insurance not compensate the Center for my treatment. All charges and co-pays are payable and due at the time of service.

Printed Name _____ Signature _____ Date _____

Mental Health Intake Form

Name of Client: _____ Person Completing Form_____

How were you referred to the Center? ____ Physician ____ Employer ____ Other _____

Do you wish for the provider to contact your referral person regarding today's visit? ___Y ___N

If yes, person's name, address, and phone_____

What brings your child in to see a provider (current stressors, issues, symptoms)?

_____

_____

_____

When did you first notice these issues? _____

Do you or the minor have any goals for treatment? _____

_____

Please list all persons who currently live with the child/adolescent and their relationship to them:

_____

_____

_____

Are there any siblings that do not reside with the child/adolescent? ___Y ___N

If yes, please list names and ages_____

_____

Family Structure

Biological Mother's Name _____ Biological Father's Name _____

Address_____ Address_____

City, State_____ City, State _____

Phone _____ Phone _____

Occupation_____ Occupation_____

Biological parents marital status ___ Currently married ___ Divorced ___ Separated ___Never Married

Please describe the child's/adolescent's family structure (i.e. nuclear, step-family, single parent home, grandparents living in home or raising the minor) _____

_____

Any current or past issues between biological parents or guardian? _____

_____

Is there any DFPS involvement? ___Y ___N

If yes, please explain _____

_____

Developmental History

Any pregnancy or delivery complications? ___Y ___N

If yes, please explain_____

_____

Were any of the following issues present during Infancy? (Feeding problems, Sleeping problems, child did not like to be held, child was not alert, growth & development problems, etc.) ___Y ___N

If yes, please explain. _____

_____

Were there any developmental delays for your child? (i.e., walking, talking, sitting up, bladder trained, bowel trained, buttoned clothing, tied shoelaces, road bike/trike, began to read, etc.) ___Y ___ N

If yes, please explain: _____

_____

Has your child had any problems with Coordination? ___Y ___ N

If Yes please explain. _____

Educational History

Does your child like school? ___Y ___N

If No please explain: _____

Has your child's performance in school changed over time (Grade changes, issues with teachers or peers etc.)? _____

Does your child receive any special services at school including behavior modification plans? ___Y ___N

If yes, please explain_____

Psychiatric History

Does your child have a history of mental health problems, or hospitalization? ___Y ___N

If yes, please complete the following:

Previous Diagnosis_____

Previous Hospitalization (Date and reason for hospitalization) _____

_____

Previous outpatient psychiatric treatment including counseling (including date, provider, interventions, and did you find treatment beneficial) _____

_____
_____

Is your child currently prescribed or have they ever taken any medications for mental health? ___Y ___N

If yes, please provide the name, dosage, dates of use, and how helpful they were if able to recall.

_____
_____
_____
_____

Is your child currently experiencing any of the following symptoms in the past 2 weeks?

(Mark all that apply)

[] Low Mood [] Anxiety/ Nervousness [] Not in touch with reality [] Isolation/Withdrawal

[] Panic Attacks [] Guilt [] Feeling Hopeless [] Feeling Worthless [] Suicidal Thoughts

[] Sleeping too Much/Little [] Obsessions/Compulsions [] Hallucinations [] Excessively Happy

[] Low Energy [] Overeating [] Aggressive Behavior [] Substance Abuse [] Overly Emotional

[] Poor Concentration [] Under Eating [] Sexual Dysfunction [] Mood Swings [] Grief/Loss [] Irritable

[] Paranoid Thoughts [] Other: _____

Family History:

Has anyone in the child's family been diagnosed or treated for a mental health condition? ___Y ___N

If yes, please provide any details you may have including diagnosis, relationship to the child, medications and if they were effective. _____

_____
_____

Does anyone in the child's family (grandparents, parents, siblings) have any medical issues? __Y __N

If yes, please provide details including what medical issue, person's relationship to the child, and age.

_____
_____
_____

Medical Information:

Does your child currently have any medical issues or concerns? _____

_____

Past medical problems, hospitalizations, or surgeries_____
_____

Please list any allergies including drugs, food, or other _____

Does your child currently take any prescription meds, over the counter meds, or supplements? __Y __N

If yes, please list name, dosage, and frequency _____

_____

_____

Substance Use:

Does your child currently use or have used alcohol or other drugs? ___Y ___N

If yes, please check all substances that apply and list, amount of use, how often, how long, and last use.

[] alcohol _____

[] amphetamines/speed _____

[] barbiturates/downers_____

[] caffeine _____

[] cocaine_____

[] hallucinogens (e.g., LSD, PCP) _____

[] inhalants (e.g., glue, gas) _____

[] marijuana _____

[] nicotine/cigarettes _____

[] other_____

Prior treatment for substance use? ___Y ___N

If yes, please provide details regarding where, when, and for what substance. _____

_____

_____

Trauma History

Does your child have history of trauma? _____

_____

_____

_____

_____

How much "of the time" does your child experience the following behaviors?				
Strengths -	**Never**	**Some**	**A Lot**	**Almost All**
Makes friends easily				
Handles changes easily				
Self-motivated				

Has a variety of interests				
Expresses thoughts and feelings verbally				
Understands what people tell him or her				
Motor coordination is developmentally appropriate				
Stays seated when asked				
Can keep quiet when necessary				
Finishes a task before moving to another				
Rarely misses school				
Respects people's property				
Is appropriate with treatment of animals				
Handles anger appropriately				
Sleeps in their own room				
Is carefree with few worries				
Maintains a healthy weight				
Seems content to be a boy/girl				
Sleeps easily and through the night				
Sees doctor for check-ups (1 time year)				
Has age appropriate ideas about sex				
In Need of Improvement -	**Never**	**Some**	**A Lot**	**Almost All**
Lacks awareness of feelings				
Does not seek comfort when stressed				
Lacks social play/interaction				
Is easily distracted				
Has difficulty paying attention				
Loses things				
Talks excessively				
Runs away from home				
Lies				
Has deliberately started fires				
Has stolen				
Has been cruel to animals				
Starts physical fights				
Has used a weapon in a fight				
Often loses temper				
Argues with adults inappropriately				
Deliberately annoys others				
Blames others when in trouble				
Worries about family members				
Avoids being alone				
Has distress when parents leave				
Is self-conscious				
Has trouble in school/grades				
Needs lots of reassurance				
Has sudden involuntary motor movements/tics				
Wets the bed and or has accidents during the day				
Seems depressed and sad				
Has physical complaints				
Has less energy than other children their age				
Sleeps too much				
Has nightmares; abrupt awakenings, or sleepwalks				
thinks weird odd strange things				
Hears voices				