Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully or ask for clarification if you do not understand an item.

CHILD, ADOLESCENT, AND FAMILY

CHILDS INFORMATION:

FULL NAME: ____________________________________ DATE: _________________________

MAILING ADDRESS: ____
(STREET OR PO BOX NUMBER)

____
(CITY, STATE, ZIP CODE)

TELEPHONE: ________________AGE: _______ BIRTH DATE: __________________ SEX: ___M ___F

CHILD'S RACE/ETHNICITY: __________ BIRTHPLACE: ___________________________________

IS THE CHILD IN SCHOOL? ___IF YES, WHICH GRADE? __ NAME OF SCHOOL:_____________________

PARENT/GUARDIAN'S INFORMATION:

FATHER/ GUARDIAN'S NAME: __________________(PHONE IF DIFFERENT) _____________________

ADDRESS OF FATHER (IF DIFFERENT):____
Street or P.O. Box

____
City State Zip Code

RACE / ETHNICITY: ________SSN #: _______________________BIRTH DATE: _________________

EMPLOYER: ____________________________ WORK PHONE: _______________________________

OCCUPATIONAL TITLE: ___________________________FULL TIME: _______ PART TIME: ________

MOTHER/GUARDIAN'S NAME: ___________________ (PHONE IF DIFFERENT) ___________________

ADDRESS OF MOTHER (IF DIFFERENT) ____
Street or P.O. Box

____
City State Zip Code

RACE / ETHNICITY: ________________ SSN #: ___________ BIRTH DATE: ___________________

EMPLOYER: ________________________________WORK PHONE: _____________________________

OCCUPATIONAL TITLE: _______________________ FULL TIME: _______ PART TIME: ___ ______

REFERRED BY: _______________________________________PHONE:_____________________________________

To be completed by therapist:

Primary Diagnosis____________________ Secondary Diagnosis_______________________

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: ____

NAME OF THE INSURED: _____________________ INSURED'S D.O.B.: __________________

INSURED'S SSN #: ________________________ INSURED'S GROUP #: ___________________

EMPLOYER: ____ AMOUNT OF CO PAY: ________

IF YOUR COUNSELING IS BEING PAID FOR THROUGH AN EMPLOYEE ASSISTANCE PROGRAM, OR ANOTHER PARTY, PLEASE LIST THE NAME OF THE PROGRAM OR PERSON, HOW MUCH THEY ARE PAYING FOR, AND HOW MANY SESSIONS ARE BEING AUTHOURIZED.NAME_________________________AMOUNT__________# OF SESSIONS________

TREATMENT AGREEMENT:

PLEASE INITIAL**:**

CO PAYMENTS ARE DUE AT THE TIME OF SERVICE. _______

I HEREBY ASSIGN PAYMENT OF INSURANCE BENEFITS DIRECTLY TO CARA DIXON-TALIAFERRO LMHC OR PINNACLE ADHD COUNSELING LLC.________

IT IS MY RESPONSIBILITY TO CONTACT MY INSURANCE COMPANY TO OBTAIN PROPER AUTHORIZATION IF REQUIRED. IF I FAIL TO DO THIS AND CHARGES ARE DENIED I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED. ________

IF YOUR PORTION OF THE BILL IS NOT PAID WITHIN 90 DAYS FROM THE LAST DATE IT WAS INCURRED A LETTER WILL SENT GIVING YOU 10 DAYS TO PAY YOUR ACCOUNT OR TO ARRANGE FOR A PAYMENT PLAN. IF YOU DO NOT RESPOND, YOU WILL BE SENT TO COLLECTIONS______

A 1% INTEREST WILL BE ADDED TO YOUR PORTION OF THE BILL THAT REMAINS UNPAID AFTER 30 DAYS_______

EVERY SESSION AFTER EAP IS $70.00 AND GROUPS ARE $25.00 ______

YOU WILL BE CHARGED $30.00 FOR MISSING AN APPOINTMENT. _______

YOU WILL BE CHARGED $30.00 FOR NOT GIVING US 24 HOURS NOTICE, WHEN CANCELING AN APPOINTMENT. _____

I HAVE RECEIVED THE TREATMENT AGREEMENT AND DISCLOSURE STATEMENT I UNDERSTAND AND AGREE TO ABIDE BY MY FINANCIAL RESPONSIBILITIES. I UNDERSTAND THAT INFORMATION WILL BE RELEASED TO MY INSURANCE COMPANY IF NECESSARY, AND ANY CHARGES THAT MY INSURANCE COMPANY WILL NOT COVER I AM RESPONSIBLE FOR.

CLIENT SIGNATURE: ______________________________________**DATE**: ______________

SIGNATURE OF RESPONSIBLE PARTY____**DATE**_________________

TO ENABLE OUR STAFF WITH ACCURATE AND CONFIDENTIAL SERVICES PLEASE COMPLETE THE FOLLOWING:

MESSAGES REGARDING APPOINTMENTS MAY BE LEFT ON MY ANSWERING MACHINE. ___YES ___NO

EMAIL MAY BE USED TO COMMUNICATE WITH ME ______YES ______NO MY EMAIL ADDRESS__________

THE FOLLOWING INDIVIDUALS MAY SCHEDULE AND OR CONFIRM APPOINTMENTS.____

____

HISTORY OF CHILD'S CURRENT PROBLEM:

DESCRIBE THE PROBLEM: ____

____

WHAT WOULD YOU LIKE TO SEE HAPPEN AS A RESULT OF OUR WORK TOGETHER:

____

WHEN DID THE PROBLEM BEGIN? ____

WHAT HAS BEEN DONE TO HELP WITH THE PROBLEM? _________________________________

DESCRIBE THE CHILD'S STRENGTHS: ____

History of Psychiatric hospitalization ________How many ______________Date_____________

History of Suicide attempt: ________ How many attempts________________ Date ____________

CHILD'S BACKGROUND INFORMATION

NAME OF PERSON GIVING INFORMATION: ____

RELATIONSHIP TO CHILD: ____

MOTHER'S INFORMATION:

PREVIOUS MARRIAGES: __________________________ YEARS OF CHILD'S LIFE LIVED WITH MOTHER: _________________

DOES MOTHER HAVE ANY SIGNIFICANT MEDICAL PROBLEMS? _________ IF YES PLEASE DESCRIBE: ___

____

HAS MOTHER HAD ANY SERIOUS ILLNESSES, ACCIDENTS, AND SURGERIES? ________IF YES, PLEASE DESCRIBE: ________

____

HAS MOTHER HAD ANY PSYCHIATRIC COUNSELING? _________ IF YES, WHEN AND WHY? ___________

____

FATHER'S INFORMATION:

PREVIOUS MARRIAGES: ___________________________ YEARS OF CHILD'S LIFE LIVED WITH FATHER:

DOES FATHER HAVE ANY SIGNIFICANT MEDICAL PROBLEMS? ___________ IF YES PLEASE DESCRIBE: _

____

HAS FATHER HAD ANY SERIOUS ILLNESSES, ACCIDENTS, AND SURGERIES? ______ IF YES PLEASE DESCRIBE: ____________

____

HAS FATHER HAD ANY PSYCHIATRIC COUNSELING? __________ IF YES, WHEN AND WHY? ____________

____

MARITAL STATUS OF PARENT / GUARDIANS:

LIVING TOGETHER SINCE: ________________ SEPARATED SINCE: ________________ MARRIED SINCE:

DIVORCED SINCE: ________ WIDOWED SINCE: ________ CURRENT LIVING SITUATION: ______________

CUSTODY INFORMATION:

DATES OF BEGINNING AND END OF MARRIAGE / RELATIONSHIP FROM WHICH CHILD WAS BORN: _________

REASONS FOR END OF MARRIAGE / RELATIONSHIP INTO WHICH CHILD WAS BORN: ________________

____

WHO HAS LEGAL CUSTODY OF THE CHILD? ____

IS THERE A VISITATION SCHEDULE? ____

IS THE CHILD ADOPTED? ________ IF YES, EXPLAIN THE CIRCUMSTANCES: ____

____

SCHOOL INFORMATION:

GRADE: ________ SCHOOL: __________________________TEACHER'S NAME: _______________________

SCHOOL COUNSELOR: ____ SCHOOL NURSE: ________________

NUMBER OF SCHOOLS ATTENDED? _______DOES THE CHILD HAVE PROBLEMS IN SCHOOL? __ IF YES, EXPLAIN:

____

ACADEMIC PERFORMANCE: ____

IF THE CHILD HAS EVER BEEN HELD BACK OR PUT AHEAD IN SCHOOL EXPLAIN: ________________

____

IF THE CHILD HAS EVER BEEN EXPELLED FROM SCHOOL EXPLAIN WHY AND WHEN: ________________

____

HAS THE CHILD EVER BEEN IN SPECIAL CLASSES? ________ IF YES, EXPLAIN WHY AND WHEN: ____

____

LEGAL ISSUES:

HAS THE CHILD EVER BEEN ARRESTED OR ON PROBATION? ________ IF YES PLEASE EXPLAIN: _____

____

PROBATION OFFICER: ________________________________ PHONE: ______________________

HAS THE CHILD EVER RECEIVED COUNSELING BEFORE? _______ IF YES EXPLAIN: ______________

ARE ANY OTHER AGENCIES INVOLVED WITH THE FAMILY? _________ IF YES EXPLAIN: __________

____

DEVELOPMENTAL AND MEDICAL HISTORY OF THE CHILD:

PLEASE CIRCLE: IS THIS YOUR NATURAL CHILD? ADOPTED? FOSTER CHILD? STEPCHILD?

IF THE CHILD IS YOUR NATURAL CHILD, WHERE DOES HE / SHE FALL AMONG YOUR OTHER CHILDREN?

(1ST BORN, 2ND BORN, 3RD BORN, OR ONLY CHILD? Etc.): ____

IF OTHER THAN YOUR NATURAL CHILD, AT WHAT AGE DID HE / SHE COME INTO YOUR FAMILY? ______

DID MOTHER HAVE ANY ILLNESS OR COMPLICATIONS DURING PREGNANCY WITH THIS CHILD? ___IF YES,

PLEASE EXPLAIN: ____

DID MOTHER TAKE ANY DRUGS, MEDICATIONS, ALCOHOL, OR TOBACCO DURING PREGNANCY? ______ IF YES,

PLEASE EXPLAIN: ____

PREGNANCY WAS PLANNED___UNPLANNED_____FULL TERM_____PREMATURE ___BIRTH WEIGHT _________

WAS THERE ANYTHING UNUSUAL ABOUT THE DELIVERY OF THIS CHILD? _______ IF YES EXPLAIN: ___

IF YOUR CHILD HAS HAD ANY PROBLEMS IN ANY OF THE FOLLOWING AREAS OF DEVELOPMENT, PLEASE BRIEFLY DESCRIBE:

SMALL MUSCLE DEVELOPMENT (FINGER/HAND COORDINATION) ______________________________

LARGE MUSCLE DEVELOPMENT (WALKING, RUNNING, JUMPING) ____________________________

SPEECH AND LANGUAGE ____

TOILET TRAINING ____

THINKING AND PROBLEM SOLVING ____

GETTING ALONG WITH OTHER CHILDREN, MAKING FRIENDS _____________________________

SELF-CARE (FEEDING, DRESSING, GROOMING) _____________________________________

OTHER ____

MEDICAL INFORMATION:

WHEN DID A PHYSICIAN LAST EXAMINE THE CHILD? ____

NAME OF PRIMARY CARE PHYSICIAN: __________________________ MAY WE CONTACT? ______

PHYSICIAN'S ADDRESS: ____________________________ PHONE: ___________________

I GIVE MY **CONSENT** FOR MY TREATMENT PROVIDER TO RELEASE MY RECORD TO MY PRIMARY PHYSICIAN SO THAT THEY CAN DISCUSS MY TREATMENT: SIGNED_______________________DATE___________

I DO NOT GIVE MY CONSENT FOR MY TREATMENT PROVIDER TO RELEASE MY RECORDS TO MY PRIMARY CARE DOCTOR TO DISCUSS MY TREATMENT: SIGHED_______________________DATE____________

LIST ANY MAJOR HEALTH PROBLEMS FOR WHICH THE CHILD IS CURRENTLY RECEIVING TREATMENT: __

____

____

LIST ANY KNOW ALLERGIES: ____

LIST ANY MEDICATIONS THE CHILD IS NOW TAKING:

____

LIST ALL MEMBERS OF THIS CHILD'S FAMILY AND OTHERS LIVING IN THE HOME:

NAME	AGE / BIRTHDATE	RELATIONSHIP	GRADE / OCCUPATION

FAMILY HISTORY:

PLEASE CHECK ALL THAT APPLY IN THIS CHILD'S FAMILY, PAST OR PRESENT:

	MOTHER	MOTHER'S FAMILY	FATHER	FATHER'S FAMILY
BIRTH DEFECT	______	______	______	______
MENTAL RETARDATION	______	______	______	
SCHOOL PROBLEMS	______	______	______	______
LEARNING PROBLEMS	______	______	______	______
MENTAL PROBLEMS	______	______	______	______
EMOTIONAL PROBLEMS				
Suicidal Behavior	______	______	______	
ALLERGIES	______	______	______	______
EPILEPSY	______	______	______	______
VISION PROBLEMS	______	______	______	______
HEARING PROBLEMS	______	______	______	______
______	______	______	______	
______	______	______	______	
ALCOHOL / DRUG ABUSE	______	______	______	______
MARITAL CONFLICTS	______	______	______	______

OTHER CONDITIONS OR PROBLEMS:

______________________ ____

____

____

Revised 04/01/2017