Dr. Tina Scott, DhA, MA, LPC

Child Intake

Completed by a parent

Form completed by: { } Parent Are you a single parent? { } Yes { } No

Child's Name: _____Gender: { } Male { } Female

Referred by: { } Parent/Guardian { } Social Services { }Other_____
Address: _____ City: _____ Zip Code: _____
Telephone: H _____ W _____ Cell _____
Parent's Email Address: _____
Therapist may leave message at : { } Home { } Work { } Cell { } Email
(Preferred:_____)

Race/Ethnicity:
_____

Emergency contact person:
_____

Relationship: _____ Phone #: _____

A copy of your Insurance & Drivers License is needed at the time of service. Please read the following carefully and sign below.

HEALTH INSURANCE INFORMATION
Insurance Company Name _____Specialty co-payment_____
Address _____ Phone# _____
Policy Holder's Name _____ Policy Holder Birth Date _____
Policy Holder's SS# _____ Relationship to Patient _____
Policy ID# _____Group# _____

If there is a secondary insurance, complete the following:
Insurance Company Name _____Specialty co-payment_____
Address _____Phone# _____
Policy Holder's Name _____Policy Holder Birth Date _____
Policy Holder's SS# _____ Relationship to Patient _____
Policy ID# _____Group# _____
Referred by (if any):_____
Are you using EAP employee assistance program? ❑ Yes ❑ No
If yes what is the name and contact number for your EAP?_____
Authorization Number_____ Number of Authorized Session_____

Assignment of Benefits and Release of Information

I give permission to Dr. Tina Scott and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 48 hours before the appointment will be billed at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions. I am aware that failure to pay unpaid balances will cause my account to be sent to collection agencies.

_____ _____
Signature of Responsible Party Date

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Consent for Child Treatment

I am the parent/legal guardian of _____ with full legal authority to consent to treatment. I give permission for Dr. Tina Scott, LPC, to provide treatment for this child, which may include assessment, advocacy, referral and mental health counseling.

Signature: _____ Date: _____

Print name: _____

Relationship to child:{ } Foster Parent { } Parent { } Guardian { } Other :_____

DOB: _____ Age: _____ Name of School: _____Grade: _____

Type(s) of service desired: { } Child therapy { } Adolescent therapy { } Family therapy

Child's main problem/major reason for seeking help at this time:

_____

How long has your child had these problems, symptoms, or issues?

_____

_____

Has your child had treatment for these issues in the past? { } Yes { } No

If Yes, was the outcome helpful? { } Yes { } No

Has your child had inpatient mental health treatment? { } Yes { } No

Briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome:

_____

_____

_____

Describe any other behavioral or emotional problems your child is having:

_____

_____

_____

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Describe the impact of your child's problems on the family:

_____
_____
_____

Describe your child's strengths and unique qualities:

_____
_____

Is your child currently under the care of a physician or psychiatrist? { } Yes { } No

If yes: Doctor's Name:_____
Phone#_____ Treatment for: _____

Is your child currently taking any medications?

{ } Yes { } No If yes, include the following information:

Name of medications

_____
_____
_____

Does this child have a history of abuse (physical, sexual, emotional, neglect)? { } Yes { } No
If yes, please describe briefly, including dates, location, perpetrators, type of abuse and impact on child/family

_____
_____ Is there legal action pending related to accusations of abuse? { } Yes { } No

If yes, describe briefly:

_____
_____
_____
_____

Is there any other legal action that may have impacted your child? Please check all that apply: If yes, describe briefly:

_____
_____

Dosage _____ _____ _____

Prescribed by _____ _____

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	Current	Past		Current	Past
Custody			Visitation		
Adoption			Child Protective Services		
Probation			Other		

BEHAVIOR CHECKLIST Please circle any of the following behaviors that concern you:

Behavior:
Crying, sadness, depression, Loss of enjoyment of usual activities, Expressing a wish to die, Bedtime fears, won't sleep, Has threatened/attempted suicide, Worries more than others, Panics, Repeats unnecessary act over and over, Has rituals, habits, superstitions, Eats very little/fasts to lose weight, Sleepwalking, Withdrawn, Nightmares, night terrors Low self-esteem, Wakes up very early, unable to go back to sleep, Tiredness, fatigue, Restless sleep, wakes frequently, Trouble going to sleep, Sleeps too much, Poor appetite, Under or overweight Over-activity, Frequently acts without thinking Doesn't finish things, Disruptive, Short attention span Daydreams, fantasizes, Easily distracted, Hallucinations Bedwetting/daytime wetting Strange or unusual behavioral

Current Past Behavior: Temper outbursts
Irritability, anger, Argues a lot, Disobedience, Does things that annoy others Unusual fears or phobias Anxious, nervous, Is overly concerned about things, Twitches or unusual movements Gorges or binge eats, Blames others for own mistakes Easily annoyed by others, Swears or uses obscene language Wanting to run away, Sneaks out at night, Injures self Stealing, Lying, Hurts animals, Destroys property ,Hurts people, Drug use, Alcohol use, Cigarette use, Sexual problems, Problems with authority Problems with the law Low motivation ,Vomits intentionally Soiling (pooping) in pants, Disorientation

Current Past Forms
of discipline used in the home: { } Time out { } Loss of privileges { } Grounding
{ } Rewards/incentives { } Extra chores { } Physical/corporal punishment
{ } Other: _____

Relationship Development Check each item that describes your child:

	Current	Past		Current	Past
Prefers to be alone			Is demanding and bossy		
Is alone a lot, but dislikes this and feels lonely			Fights with others		
Is shy			Bullies others		
Has few friends			Teases a lot		
Has many friends			Plays with younger kids		
Plays with “problem kids”			Plays with older kids		
Is picked on a lot			Poor relationships with peers		
Is oversensitive			Conflict with parents/step-parents		
Poor relationships with teachers			Has difficulty getting along with brothers and sisters		

School Check any area of concern:

Dr. Tina Scott
CHILD INTAKE
1445 City Avenue
Wynnewood, PA 19096
215-519-2531

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	Current	Past		Current	Past
Dislikes school			Missed many school days		
Works hard but does not do well			Repeated a grade		
Unmotivated, refuses to complete work			Discipline referrals, detentions		
Learning problems			Suspensions (how many? ___)		
Expulsions (how many? _____)					

If your child has been suspended or expelled, please explain:

_____

School Environment Check all that apply:

	Current	Past		Current	Past
Resource classes/special ed.			Continuation school		
Gifted program			Home study		
Speech therapy			Independent study		
Other programs					

If other programs, please explain:

_____

Family Stresses Check all that applies:

	Current	Past		Current	Past
Marital problems			Housing problems		
Marital separation			Legal issues		
Divorce			Death of a friend		
Custody disputes			Death of a relative		
Financial problems			Death of a pet		
Job loss			Family illness		
Parents using alcohol/drugs			Other stressors:		

If other stressors please describe:

_____

_____

Developmental History During pregnancy, did mother:
{ }drink{ }drugs{ }illness{ }accident{ }problems with labor{ } problems with delivery
{ } problems with pregnancy If yes, please describe:

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_____

_____

Please check if child is/was delayed in any of the following areas: { } holding head up
{ } turning over { } sitting up { } crawling { } walking alone { } weaning { } feeding self
{ } toilet training { } using single words { } using sentences { } dressing self { } sleeping through night
Briefly explain any delays:

_____

_____

___ As a baby/toddler, was child: check all that apply
{ } eating well { } colicky { }head banging { } performing rocking behavior { } clumsy
{ } easy to regulate (sleeping/eating) { } wanting to be left alone { }adaptable to transitions{ } more interested in things than people { } easy to soothe { } performing daredevil behavior

Medical History Indicate if your child has had any of the following:

Condition	Yes	No	Age	Details
Serious Infection				
Convulsions/seizures				
Head injuries				
Other injuries				
Hospitalizations				
Surgeries				
Ear infections				
Poisonings				
Allergies				
Asthma				
Alcoholism				
Drug Use				
Sexual Problems				

Does your child have any other medical conditions? { } Yes { } No
If yes, please describe:

_____

_____

Does your child frequently complain of bodily aches and pains? { } Yes { } No
If yes, please describe:

_____

_____

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Does your child miss school because of his/her physical complaints? { } Yes { } No
If yes, please describe:
_____
_____

Does your child have any allergies to medications, drugs or foods? { } Yes { } No
If yes, please describe: _____
_____
_____

Family Information: List all of the people who currently live with the child

M/F	Age	Relationship	Name

Indicate if any family members or relatives have the following:

	Mother		Father		Brother		Sister		Other	
Problem:	Now	Past	Now	Past	Now	Past	Now	Past	Now	Past
Problems with attention, activity or impulse control as a child										
Learning disabilites										
Did not graduate from high school										
Alcohol abuse										
Drug use										
Problems with aggressive behavior as adult or child										
Antisocial behavior (arrests, jail, legal problems, probation, other										
Abuse victim										
Abusive to others										
Depression										
Nervous disorders										
Mental retardation										
Serious illness or surgeries										
Physical handicaps										
Tics or unusual movements										
Other mental problems										

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What are your family supports? (church, friends, clubs etc.)

_____

_____

What are your family strengths?

_____

_____

Additional comments:

_____

Please list any adults who are authorized to drop off or pick up your child from his/her therapy session in the event you or another legal guardian is unavailable:

Name	Relationship to child

Please note: An authorized adult must remain in the waiting room at all times when a minor is in a therapy session. I authorize the above named person(s) to drop off or pick up my child from his/her therapy session. I agree that I or any person named by me (listed above) will not leave the premises and will remain in the waiting room for the duration of my child's therapy session.

_____ Child's Name

_____ Print Parent/Guardian Name

_____ Signature

_____Date of Birth

_____Relationship to child

_____ Date