Child/Adolescent Intake Packet

Contact and Demographic Information

Name of child/adolescent____

Date of birth_______________ Age________ Ethnicity ___________________________________

Name of person filling out this form ____

Relationship to child____

Who has legal custody?

____

Primary Address

____

____

Phone Contacts

Name______________________ Number ___________________ OK to leave msg ___Yes ___No

Name______________________ Number ___________________ OK to leave msg ___Yes ___No

Name______________________ Number ___________________ OK to leave msg ___Yes ___No

Name______________________ Number ___________________ OK to leave msg ___Yes ___No

Email Contact

Primary email address____

Is it ok to email you regarding appointments and billing information using a nonsecure email?
___yes ___no

Emergency Contact

Name________________________Relationship________________Phone_____________________

Financial Guarantor (financially responsible person) Information

Name________________________________ Relationship_________________ DOB___________

Address____

City______________________________ State______ Zip________

Primary Care Physician

Name ______________________________Phone _________________ Fax ___________________

Reason for seeking treatment

Please describe why you are seeking services:

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Please describe your expectations for treatment/ goals for therapy:

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Notes

Please check any of the symptoms/behaviors that you are concerned about

__Very unhappy	__Irritable/ angry	__Steals	__Skips school	__Temper outbursts	__Overactive	__Lacks motivation	__Disobedient
__Fearful	__Clumsy	__Trouble with the law	__Sexual acting out/sexual concerns	__Strange behaviors	__Withdrawn	__Impulsive	__Acts young for age
__Distractible	__Phobic	__Shy/anxious around others	__Lying	__Strange thoughts	__Sleep problems	__Short attention	__Mean to others
__Conflict with peers	__Worries	__Runs away	__Fire Setting	__Hallucinations	__Nightmares	__Stomachaches	__School anxiety
__Destructive	__Stubborn	__Poor hygiene	__Eating problems	__Drug use	__Hyperactive	__Toileting problems	__Talk of suicide/suicidal behaviors
__Agitated	__Negative/ pessimistic	__Forgetful	__Day dreams	__Alcohol use	__School problems	__Fatigue	__Harm to others/ talks of harming others
__Crying	__Recurring/ disturbing memories	__Obsessive thoughts or compulsive behaviors	__Suspicious/ paranoid	__Frequent arguments	__Hears voices	__Oppositional/ Defiant behavior	__Self-injurious/self-mutilation

Other concerns:

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Notes

Family Information

Relationship	Name	Lives with child Yes/No	Age	Quality of relationship
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Other relatives				

Has the child been adopted? __Yes __No

Has the child ever been placed in foster care? __Yes __No

Has there been any involvement with Child Protective Services? __Yes __No

__ Parents are legally married __ Parents are living together

__ Parents are divorced __ Parents are separated

__ Parents have never lived together

Father has remarried? __Yes __No If yes, number of times ___

Mother has remarried? __Yes __No If yes, number of times ___

Family Information Continued

Family Mental Health Concerns	Family Member(s)
Hyperactivity/impulsivity	
Inattention	
Sexual abuse	
Physical abuse	
Emotional abuse/neglect	
Autism	
Depression	
Bipolar Disorder	
Suicide	
Anxiety	
Panic attacks	
Obsessive-compulsive behaviors	
Anger/abusive	
Schizophrenia	
Eating Disorder	
Alcohol/drug abuse	

Additional family information:

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Notes

Medical Concerns

Please check any of the following medical conditions the child/ teen has experienced:

__Significant allergies	__Chronic pain	__Dizziness/fainting	__High fevers	__Chronic ear infections
__Asthma	__Surgery	__Toileting problems	__Headaches	__Serious accident
__Head injury	__Seizures	__Hearing problems	__Sleep problems	__Stomach aches
__Vision problems	__Recent changes in weight	__Recent changes in mood	__Recent changes in energy level	__Recent changes in sleep

Describe any past medical concerns not listed above:

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Describe any current medical concerns not listed above:

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____

Current prescription medications:

Medication	Dosage	Prescribed by	Date first prescribed

Current over-the-counter medications (including vitamins, herbal remedies, etc):

____

Notes

Birth History and Developmental Milestones

Were there any problems during the pregnancy or delivery?

___Yes ___No

If yes, please describe

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Was the pregnancy full-term?

___Yes ___No If no, how many weeks? _________________

Did the biological mother use any tobacco, medication, street drugs or alcohol while pregnant? ___Yes ___No

If yes, please describe

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Were there any concerns or developmental delays in early childhood?

___Yes ___No

If yes, please describe

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Notes

Trauma History

Please check any trauma the child/teen as experienced:

__Emotional abuse	__Neglect	__Parental separation	__Teen pregnancy	__Crime victim
__Sexual abuse	__Violence in the home	__Multiple family moves	__Homelessness	__Parent illness
__Physical abuse	__Parent substance abuse	__Parent illness	__Loss of a loved one	__Financial stress

Other:____

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Notes

Previous Mental Health Treatment

	When	Provider/Program	Reason for treatment
Outpatient counseling			
Medication management			
Psychiatric hospitalization			
Drug/alcohol treatment			

Other:____

____

Previous or current interventions/services

	When	Provider/Program	Reason for treatment
Early intervention services			
Occupational therapy			
Speech/Language therapy			
Physical therapy			
Vision therapy			
Feeding therapy			

Other:____

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Notes

Interests and Strengths

Please describe interests, hobbies and strengths:

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School Information

Current grade level ____________

This year's school grades __Excellent __Good __Fair __Poor

Past school grades __Excellent __Good __Fair __Poor

Have there been any concerns related to school performance? __Yes __No

If yes, please describe:

____

Have there been any of the following at school?

__In or out of school suspension(s) __Difficulty with homework

__Referrals/detentions __Attendance problems __Bullying

Has the child/teen ever been diagnosed with a Learning Disability? __Yes __No

Does your child/teen have an IEP or 504 Plan at school? __Yes __No

Have there been any other school related concerns? __Yes __No

If yes, please describe:

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Notes

Substance Use

Any current or past concerns with substance use? __Yes   __No

If yes, please describe:

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Additional Information

Please add any other information that would be important to share:

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Thank you for taking the time to complete this information packet.

Notes

Insurance Agreement & Fee Contract

Portland Trauma Recovery

SERVICE FEES:

$225 per session. Sessions typically run 45-50 minutes in length.

Payments are made to the therapist each session. Your therapist will provide a receipt upon request. You must cancel appointments 24 hours in advance or you will be charged a $70 minimum cancellation fee.

Non-payment of two consecutive sessions will require the negotiation of a payment plan and review of this Fee Contract.

Services can be discontinued due to non-payment of balances over 60 days.

INSURANCE AGREEMENT:

If I choose to use my insurance, I understand that diagnosis and treatment information will be shared with my insurance company for billing and treatment authorization.

I understand that I remain responsible for co-pay, coinsurance and deductible amounts.

I must notify Portland Trauma Recovery of insurance changes and/or discontinuation of coverage.

I remain responsible for all fees refused or unauthorized by my insurance plan.

Primary Insurance Company:	ID#:	Group Name or #:
Primary Insured Person:	Name:	Date of Birth:

Secondary Insurance Company:	ID#:	Group Name or #:
Primary Insured Person:	Name:	Date of Birth:

Name of Client ____

Parent/Guardian Signature: ___________________________________ Date: _____________________

Printed Name of Parent/Guardian: ____

Signature of client if 14 years of age or older ___________________________________ Date: _______

Confidentiality & HIPAA Privacy Protection

Portland Trauma Recovery

Your personal information, records and treatment at Portland Trauma Recovery is Protected Health Information (PHI) and we are required by law to notify you of the following:

There are some exceptions to privacy and confidentiality. Below are areas where information may be shared for safety, quality of care and business purposes:

- Healthcare information is shared with insurance companies and vendors for billing, authorization, treatment and record keeping purposes.
- Office staff has access to some PHI, but only when it is relevant to their job.
- Providers share limited information when they consult on client treatment.
- If you sign a Release of Information form requesting specific information to be released to a designated individual or organization, especially for the coordination of your medical care and services.
- If there is a court order to release your records to legal authorities
- Mandated Reporting – if there is a clear possibility of harm to you, a child, or someone you have discussed, specifically in cases of: suicidal and homicidal threats, abuse or neglect of a child or vulnerable adult, specific infectious and communicable diseases. Portland Trauma Recovery will inform and involve you if a mandated report is required.
- To consult with or provide records to a non-custodial parent, unless otherwise ordered by the court.

You have a right to your own information and/or your dependent's, and can revoke authorization to release your records, specifically:

- You have a right to decide how we contact you.
- You have a right to review your file.
- You have a right to amend your file and submit a written request for corrections.
- You have a right to a copy of this notice.
- You have a right to request a list of where your records have been sent.
- You have a right to revoke past authorizations that you have signed.

If you have questions regarding this Privacy Notice or if you feel your privacy rights have been violated, please write Lorri Asder, Portland Trauma Recovery, 2105 NE Cesar E Chavez Blvd #200, Portland, OR 97212.

You may also file a complaint with Secretary of the Department of Health and Human Services: Hubert H. Humphrey Blvd, 200 Independence Ave SW, Washington DC 20201.

Name of Client ____

Parent/Guardian Signature: ___________________________________ Date: _____________________

Printed Name of Parent/Guardian: ____

Signature of client if 14 years of age or older ___________________________________ Date: _______