PINNACLE
Mental Wellness Group
A Family Counseling Community, Inc.

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Child Intake Form - Counseling

Childs Name _____ Age _____ Birthdate _____

Family Information and History:

Who does the child reside with? Please check all that apply and list the percent of time that child reside with each listed person.

- ☐ Both natural parents - % time _____
- ☐ Natural mother - % time _____
- ☐ Natural Father - % time _____
- ☐ Stepmother - % time _____
- ☐ Stepfather - % time _____
- ☐ Guardian, please specify: _____
- ☐ Other: please specify _____

Please list the address for each person that the child resides with:

Person #1: _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____

Person #2: _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____

Person #3: _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____

Person #4: _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____

Please list all siblings (whether they reside with your child or not):

Name age/ of Sibling 1:	Resides with Relationship/Name:	Address Phone/Number:
Name age/ of Sibling 2:	Resides with Relationship/Name:	Address Phone/Number:
Name age/ of Sibling 3:	Resides with Relationship/Name:	Address Phone/Number:
Name age/ of Sibling 4:	Resides with Relationship/Name:	Address Phone/Number:
Name age/ of Sibling 5:	Resides with Relationship/Name:	Address Phone/Number:
Name age/ of Sibling 6:	Resides with Relationship/Name:	Address Phone/Number:

Does your child get along well with family members? If no, please explain: _____

_____

_____

If Client is a minor, name of responsible adult: _____

Name of closest relative not living with child _____

Address _____ City _____ State _____ Zip _____

Medical Information and History:

Name of child's pediatrician: _____

Last Medical Examination _____ Reason _____

Is your child now under a doctor's care?_____ If yeas, doctor's name: _____

Reason for doctor's care _____

Is your child taking any Medication? _____ If yes, please list name(s) and dosage? _____

_____

Reason for medication(s): _____

Has your child ever been diagnosed with a chronic illness? If yes, please explain: _____

_____

Has your child ever been hospitalized? If yes, please explain: _____

_____

Social/Mental/Emotional Information and History:

Has your child ever been hospitalized for a mental illness? Describe: _____

_____

Has your child ever been diagnosed with any of the following (please check all that apply):

☐ Depression	☐ Eating Disorders	☐ Suicidal Ideation/Attempt
☐ Bipolar Disorder	☐ Anxiety Disorder	☐ Cutting/Self-harming
☐ Phobias	☐ Bedwetting	☐ Enuresis/Encopresis
☐ Mutism	☐ Trichotillomania	☐ Personality Disorder
☐ ADD	☐ ADHD	☐ Obsessive-Compulsive Disorder
☐ Mental Retardation	☐ Asperger's	☐ Developmental Delay
☐ Separation Anxiety	☐ Autism	☐ Posttraumatic Stress Disorder

Please explain any checked items:_____

_____

Does your child have friends? If no, please explain: _____

_____

Does your child have a best friend/friends? _____

_____

Does your child make friends easily? If no, please explain:_____

_____

Is your child able to maintain friendships? If no, please explain: _____

_____

Does your child complain about his/her friendships regularly? If yes, please explain:_____

_____

School Information and History:

What grade is your child in? _____ Who is your Child's teacher(s): _____

What school does your child attend? _____

Address: _____

Phone Number: _____

What kind of grades does your child receive?_____

Do you think your child is working at, above, or below his/her academic potential? Please describe your answer: _____

_____

_____

Does your child's teacher think your child is working at, above, or below his/her academic potential? Please explain your answer: _____

_____

_____

Has your child has an SST (Student Study Team) Meeting? If yes, what was the date? What was the outcome?_____

_____

Does your child have an IEP? If yes, what was the date of the last meeting? Please provide a copy for your child's file. _____

Has your child been diagnosed with a learning disability? If yes, please describe: _____

_____

Does your child experience academic problems at school? If yes, please describe:_____

_____

Does your child experience behavioral problems at school? If yes, please describe:_____

_____

Is your child involved in any extracurricular activities (sports, clubs, music, lessons, etc)? If yes, please describe and give schedule:_____

_____

_____

Previous Therapy History:

Has your child had any previous therapy/counseling?If yes, name and phone numbers of all therapists: _____

Approximate beginning and ending date your child saw each therapist: _____

Type of Therapy/Counseling:_____

How was your child referred to Pinnacle Mental Wellness Group?:_____

_____

What do you hope your child will achieve with therapy? _____

_____

_____

_____

_____

If applicable, what does your child hope he/she will achieve with therapy? _____

_____

_____

What have you told your child about therapy and why he/she is here? _____

_____

_____

What questions does your child have about therapy? _____ _____

_____

_____

Check Any of the Following That May Apply to You:

- ☐ Headache
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ No Appetite
- ☐ Over-Eating
- ☐ Stomach Trouble
- ☐ Bowel Disturbances
- ☐ Always Tired
- ☐ Lying
- ☐ Unable To Relax
- ☐ Insomnia
- ☐ Recurrent Dreams
- ☐ Nightmares
- ☐ Sibling Rivalries
- ☐ Does Not Have Friends
- ☐ Inferiority Feelings
- ☐ Feel Tense
- ☐ Cries Easily/Often
- ☐ Fears and Phobias
- ☐ Obsessions
- ☐ Depressed
- ☐ Suicidal Ideas
- ☐ Drug or Alcohol Use
- ☐ Allergy
- ☐ Asthma
- ☐ Hearing Problems
- ☐ Difficulty Reading
- ☐ Difficulty Hearing
- ☐ Dyslexia
- ☐ Difficulty talking
- ☐ Hallucinations
- ☐ Shy With People
- ☐ Can't Make Friends
- ☐ Afraid of People
- ☐ Home Conditions Bad
- ☐ Unable to Have a Good Time
- ☐ Always Worried
- ☐ Over-Ambitious
- ☐ Difficulty Making Decisions
- ☐ Lack of Motivation
- ☐ Difficulty Following Directions
- ☐ Perform Repetitive Behaviors
- ☐ Wears Reading Glasses
- ☐ Repeats Words/Phrases

Other issues of concern (please list): _____

_____

Payment and Insurance Information:

PLEASE NOTE: ALL FEES NEED TO BE PAID AT THE TIME OF SERVICE. There are three options, outlined below, for payments and billing. Please choose the option that best suits your need below by ***initialing*** your choice.

Name of financially responsible person: _____

_____
Initial Choice

I would like PMWG to Superbill my insurance on my behalf.

If you want us to Superbill your insurance for you, please provide the following information:

- Name of Insured: _____
- Insured's Date of Birth: _____
- Relationship to client: _____
- Insured's Address: _____
- Insured's phone #: _____
- Insured's Employer: _____

Please also provide a copy of your insurance card, front and back.
PLEASE NOTE: As a courtesy to our clients we will bill your insurance on your behalf. However, you are still responsible to pay for the all session/treatment fees upfront and on the day of service. Your insurance, if it covers our services, will reimburse you directly.

_____
Initial Choice

Credit Card payment option

Yes, I want my credit card billed for my child's session. You can elect to have a credit card on file that will be automatically billed after each of your child's session are completed. If you would like to use this payment option please fill out the **Credit Card Form**.

_____
Initial Choice

I have CCHP or another In-network Insurance for my child.

I am a member of CCHP Insurance or another in-network insurance company and I have already called and have a valid authorization in place for my child's treatment, if one is required. I understand that whatever fees are not covered by my insurance (late fees, insufficient funds for co-pays, additional testing fees, lapse in coverage, etc) are my financial responsibility.

Upon my signature below, I hereby attest that all of the information furnished is true and correct.

Signature _____ Date _____

Print Name _____ Relationship to Child _____