Newport Counseling Center, LLC

Intake face sheet

Client's Name: ______________________________ Referred by:__________________________________
Address: __________________________________City:__________________________Zip:_______________
Phone: (H)____________________(W)________________(cell)___________________________________
SS#:_________________Age:_____ Birth Date:____________ Email: ______________________________
Ocupation: _____________________________________ Employer/School:__________________________
Insurance Company:_________________________ Cardholder name:_________________________________
Insurance ID#_____________________________Group#_____________________________________
Name and phone number of emergency contact person (not living in your house).
____

If client is UNDER 18 years of age, please complete this section:

Mother:_____________________________ Phone:(H)___________________(C)___________________
Address:____ (W #):______________________
Birth Date: _______________________ Email: ____
Employer/Occupation:_______________________ Insurance ID#______________________
Insurance Carrier:___________________________Group#: _______________________________

Father:______________________________Phone:(H)_______________(W)________________________
Address:____Cell:______________________________
Birth Date: ______________________ Email: ____
Employer/Occupation:________________________Insurance ID#______________________________
Insurance Carrier:___________________________Group#: ______________________________________

I consent to release any medical or other information necessary to process this claim. In addition, this signature authorizes payment of medical benefits to the provider for services rendered. I understand that if my insurance does not pay the claim, I am responsible for payment of all charges for services rendered. I also understand that I am responsible for any co-pays at the time of service at the specialist rate. It is the responsibility of the client to know what their insurance benefits are.

Signature: ____Date:_____________________
(Parent/Guardian must sign if client is under 18 years old)

Cheryl Woodcock, LCSW ❖ Melissa Hixson, LCSW ❖ Lori Amey, LCSW
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Consent for Treatment
Acknowledgment of Policies & Rights

I, ____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for treatment for the minor or person under my legal guardianship mentioned here: _________________________________at NEWPORT COUNSELING CENTER LLC, hereby referred as NCC. The rights, policies, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. NCC encourages that this decision be discussed with the treating therapist. This will help facilitate a more appropriate plan for discharge.

Privacy of Information Policy (see Client Policy Packet)
I certify that I have received a copy of the Privacy of Information Policy. __________(initial)

Conditions for Treatment Termination (see Client Policy Packet)
I certify that I have received a copy of the Conditions for Treatment Termination Policy. ________(initial)

By signing below, I give my consent to treatment and agree to abide by the policies and agreements with Newport Counseling Center, LLC.

____ Date: __________________
Client Signature (14 yrs and older)

-OR-

____ Date: _________________
Signature of Parent/Legal Guardian

____ _________________
Witness Date

ADOLESCENT INFORMATION FORM

(revised 7/2018)

Name_______________________________________ Date of 1st Appointment____

Date of Birth _______________________ Age _______ Gender: Male________ Female________

MEDICAL HISTORY

Name of Primary Care Physician: ____

Physician's Address:____Physician's Phone:__________________________

Date of last medical evaluation:______________________ Date of next appointment:_______________________________

Please list any medical conditions below:

____

____

____

____

Please list medications on separate medication log attached

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
___________________________________	__________	____
___________________________________	__________	____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:____

____

____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

____

____

____

Do you have any allergies? If so please list them below:

____

____

Any adverse reactions to medications:

____

____

____

____

MEDICATION LOG

Name of medication	Amount prescribed x taken per day	Who prescribed it?	Date of increase in dose/frequency

CHILD and ADOLESCENT ADDENDUM TO THE CLINICAL ASSESSMENT

PRENATAL, PERINATAL AND DEVELOPMENTAL EVENTS and HISTORY

- PREGNANACY
-
- ☐ Normal and routine

  ☐ Problematic ______________________________

  ____

  ____

- FETAL HEALTH prior to birth Include child's exposure to substances during gestational development: amounts, frequency and duration

  ☐ Alcohol ______________________________
  ☐ Illicit drugs ______________________________
  ☐ Prescriptive medications ______________________________
  ☐ Tobacco ______________________________
  ☐ Caffeine ______________________________

- GESTATION: Born at ____________ weeks. Came home at ____________ weeks.

- BIRTH

☐ Routine delivery ☐ Without complication
☐ With complications

____

☐ Cesarean delivery ☐ Without complication
☐ With complications

____

- DEVELOPMENTAL HISTORY AND MILETONES

	Within Normal Limits	Notes-(Grades, relationship with siblings, daycare, discipline)
Sat up	☐	______________________________
Pulled UP	☐	______________________________
Walked	☐	______________________________
Off Bottle	☐	______________________________
Used Cup	☐	______________________________
Fed self	☐	______________________________
Toilet Training	☐	______________________________
Spoke first word	☐	______________________________
Spoke in Sentences	☐	______________________________
Acclimated/transitioned to school	☐	______________________________
______________________________	☐	______________________________

- PARENTAL CONCERNS OF NOTE

Name: ________________________
Date: _________________________

SCHOOL AND FAMILY HISTORY

Do you experience any academic problems while in school? (Circle One) YES NO

If yes, please explain:____

What was the last year of school you completed? _______What school are you currently attending? ________________________

Who is in your current support network? (friends, relatives, other adults):____________________________________

____

Please check all information which applies to your biological parents:

MOTHER		FATHER	
	____ living		____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times

With whom do you live? Mother____ Father____ Stepmother____ Stepfather____ Guardian ____ Grandparent____

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

____

List first names and ages of your brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:

Are any of these siblings receiving mental health services or have they in the past? If yes do you know why and with whom?

____

____

Have you ever received services before or are you currently receiving services from an outpatient therapist, mobile therapist, TSS, children and youth worker, case manager or other? If so with whom and what did you like and/or dislike about that experience? ____

____

____

Others living in the home with you who are not related to you.

Name	Age	Relationship	Grade/Occupation

Describe your relationship with your mother:

Currently:____

____

In the past:____

____

Describe your relationship with your father:

Currently:____

____

In the past:____

Name:______________________________

Date:______________________________

Describe your relationship with your stepmother:____

____

Describe your relationship with your stepfather:____

____

Describe any problems that have occurred in your family relating to:

Alcohol/drug abuse:____

____

Sexual/physical/emotional abuse:____

MENTAL STATUS

Please check any of the following that describe how you believe you feel:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful
____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless
___annoyed

Describe any other feelings you have had:____

Please check any of the following risk-taking behaviors you have engaged in:

___street racing ___gang involvement ___skip school ___dropped out ___dangerous dieting ___cutting ___stealing

___unprotected sex ___running away ___bullying others ___fire starting ___hurt animals ___restrict or restricted food intake

___over exercise

Please check any of the following alcohol/drugs that you currently or have previously used:

____beer ____wine ____hard liquor ____pot ____cocaine ____heroin ____Ecstasy ____speed ___over the counter drugs

____prescription drugs ____Triple C's ____cigarettes Other:_________________________________

Frequency of use of any of the above past and/or present: ____

____

____

When did you last use any unprescribed drugs? ____

Describe any withdrawal/DT/Seizure history:____

____

Describe the past and/or present treatment for the item above:_____________________________________

____

Have you had any change in sleeping habits? (Circle One) YES NO

Describe:____

Have you had any change in eating habits? (Circle One) YES NO

Describe:____

Are you considering suicide in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description:____

Have you ever considered suicide in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_______________________________________

Are you having any homicidal thoughts in regard to your **current** problem? (Circle One) YES NO

If yes, please explain:____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain:____

Name:______________________________

Date:______________________________

LEVEL OF FUNCTIONING

List any current problems you are having in daily home, social or school functioning (i.e. isolation from friends/family, significant difficulty getting to school or completing daily tasks, parent's recent divorce or problems with peers, getting along with family members):____

____

____

What activities or hobbies do you participate in?____

____

____

Do you participate in regular exercise? (Circle One) YES NO

Describe:____

How much time do you spend online or gaming?____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

____

____

____

____

____

Please list your therapy goals:

____

____

____

____

____

Are there any cultural preferences you would like Newport Counseling Center to be aware of ? ____________________

____

____

THANK YOU!