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: SEE CARD COPY Cardholder name:SEE CARD COPY
Insurance ID# SEE CARD COPY Group# SEE CARD COPY
Name and phone number of emergency contact person (not living in your house).
_____

If client is <u>UNDER 18 years</u> of age, please complete this section:

Mother:_____ Phone:(H)_____(C)_____
Address:_____ (W #):_____
Birth Date: _____ Email: _____
Employer/Occupation:_____ Insurance ID# SEE CARD COPY
Insurance Carrier: SEE CARD COPY Group#: SEE CARD COPY

Father:_____Phone:(H)_____(W)_____
Address:_____Cell:_____
Birth Date: _____ Email: _____
Employer/Occupation:_____Insurance ID# SEE CARD COPY
Insurance Carrier: SEE CARD COPY Group#: SEE CARD COPY

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
Tina Herr, LSW ❖ Samuel Lowe, LCSW ❖ Julie Martzall, LSW ❖ Sarah Kimber, LSW

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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

CHILD INFORMATION FORM

(revised 7/2018)

Name:_____ **Date of 1st Appointment:**_____

Date of Birth:_____ **Age:**_____ **Gender:**_____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____Physician's Phone:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Please list your child's medications on the attached med log

Has your child ever been hospitalized for medical or psychiatric reasons? (**Circle one**) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems your child experiences: _____

_____

_____

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

_____

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

_____

Does your child have any allergies including allergies to medications? _____

_____

_____

Has your child ever drank alcohol or been caught smoking or sniffing substances to get "high"? _____

_____

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 HISTORY

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers? (**Circle One**) YES NO

If yes, please explain: _____

_____

What was the last year of school your child completed? _____

What school is he/she attending? _____

Please check all information which applies to your child's **biological** parents:

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

With whom does your child live: _____

Custody and/or visitation orders in place: _____

_____

Does your child consider anyone else to be a "parent" in his/her life? (**Circle One**) YES NO

If so, whom? _____

Describe your relationship with your child:

Currently: _____

_____

In the past: _____

_____

Describe your child's relationship with his/her other parent:

Currently: _____

_____

In the past: _____

_____

List first names and ages of your child's brothers & sisters:

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

Name:_____

Date: _____

Describe any problems which occurred in your child's family relating to:

Alcohol/drug abuse: _____

Sexual/physical/emotional abuse: _____

Others living in the home with your child:

Name	Age	Relationship	Grade/Occupation
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you believe your child has been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful

____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ___helpless

____Other, Explain: _____

Describe any behaviors your child has demonstrated that cause concern: _____

_____

Has your child had any change in sleeping habits? (Circle One) YES NO

Describe any changes: _____

_____

Has your child had any change in eating habits? (Circle One) YES NO

Describe any changes: _____

_____

Is your child considering suicide in connection with his/her current problem? (Circle One) YES NO

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

Has your child ever considered suicide in the past? (Circle One) YES NO

Has your child *attempted* suicide recently or in the past? (Circle One) YES NO

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

_____

Has your child hurt others or animals or thought about harming others/animals recently or in the past? YES NO

If yes, please explain: _____

Is the child you are seeking services for here, receiving services from another agency at this time for wrap services, family based services, children and youth, case management or other? (Circle One) YES NO

If so, which agency: _____

Has your child or any of the children listed above received mental health services in the past? Yes or No

If the answer is "yes" to either of the questions above, what agency(s) are/were they being served by and what was/is the type of services (family based/case management/wrap):

_____

_____

_____

Name:_____

Date: _____

LEVEL OF FUNCTIONING

Please describe what activities your child participates in: _____

_____

Who is in your child's support network? _____

_____

Please describe your child's level of physical activity: _____

_____

How much time does your child play on the computer, watch TV, or play video games: _____

_____

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

_____

_____

Please list your therapy goals for your child:

_____

_____

_____

_____

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

_____

_____

THANK YOU!

Mental Health Treatment Plan

Patient Name:_____ **Patient ID#:** _____ **Date:** _____

Problem #1: _____

Current Impairments/
As Evidenced By: _____

Long Term Goal: _____

Short Term Objectives: _____

Interventions: _____

Referrals/Resources Recommended: ☐ Support Group/Community Resource _____ ☐ Psychiatrist
☐ Bibliotherapy ☐ Journaling ☐ Other Homework ☐ Addiction/Dependency Referral _____
☐ Adjunct Treatment _____

Problem #2: _____

Current Impairments/
As Evidenced By: _____

Long Term Goal: _____

Short Term Objectives: _____

Interventions: _____

Referrals/Resources Recommended: ☐ Support Group/Community Resource _____ ☐ Psychiatrist
☐ Bibliotherapy ☐ Journaling ☐ Other Homework ☐ Addiction/Dependency Referral _____
☐ Adjunct Treatment _____

Anticipated Frequency of Visits: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other: _____
Anticipated Length of Treatment Episode: _____

This plan has been discussed with the patient who ☐ agrees with the plan ☐ objects to the plan for the following reasons _____

_____ _____
Patient/Parent/Guardian (optional) **Date**

_____ _____
Practitioner Signature (required) **Date**

Revised 5/7/98