

APPLICATION FOR SERVICES

Date: _____

Name: _____

Date of Birth: _____

Client's Name: _____

Primary Language: _____

Sex: M: ___ F: ___ T: ___

Home Phone: _____ School: _____ Grade: _____

Please list emergency contact: _____

Relationship: _____ Age: _____ Occupation: _____

Address: _____

Phone: _____ Email: _____

Preferred method of contact: _____ Able to leave message: _____

Parent/Guardian #1 Name (if different from above): _____

Relationship to client: _____

Marital Status: _____ Age: _____ Occupation: _____

Is address the same as the client?: _____ If no, enter the address below:

Phone: _____

Married: _____ Divorced: _____ Widowed: _____

Parent/Guardian #2 Name (if different from above): _____

Relationship to client: _____

Marital Status: _____ Age: _____ Occupation: _____

Is address the same as the client?: _____ If no, enter the address below:

Phone: _____

Married: _____ Divorced: _____ Widowed: _____

APPLICATION FOR SERVICES (Continued)

Please list other immediate family members:

Name: _____

Relationship to client: _____

Marital Status: _____ Age: _____ Occupation:

Address: _____

Phone: _____

REFERRAL INFORMATION

Reason for Referral (What is the main issue for which you are seeking help at this time?):

How often does this issue or behavior occur? (5x/day, 2x/week, etc.):

How long has this been happening?:

How is this affecting you at home? In school? In peer relationships?:

Has the person been seen previously for psychological or psychiatric consultation?: _____ If
yes, name of professional:

Dates of service: _____

Was an evaluation completed?: _____

What type of evaluation?: _____

If there has been a past evaluation, please bring a copy of the evaluation to the first visit. We will have you complete a consent form in the office to allow us to communicate with your prior professional.

How were you referred to this practice?:

MEDICAL INFORMATION

Please describe client's present state of health?:

Please list client's medical issues:

Please list any current medications:

Please list client's PCP and practice:

Please list history of surgeries or serious illnesses:

Please list allergies:

Please list caffeine, tobacco, alcohol or other drug use:

MEDICAL EVALUATION REQUIREMENT

A.

I have had a physical exam within the past 6 months and authorize my physician to release a summary of findings and medical status to Rita Vatcher, LMHC (see attached release).

B.

I have not had a physical examination in the past 6 months, but will seek one out within the next month and release a summary of findings and medical status to Rita Vatcher, LMHC.

If you do not have a primary care physician, we will give you the names of three health care providers whom you may contact. (Client to bring release of information to his/her physician at time of exam) Signature: _____ Date: _____

C.

I have not had and refuse to seek, or refuse to release the results of a physical examination to Rita Vatcher, LMHC.

Reason for refusal:

Signature: _____ Date: _____

FAMILY HISTORY

Please indicate if any of the following issues are currently being experienced within the immediate family (parents, siblings):

- | | |
|--|---|
| <input type="checkbox"/> Marital difficulties | <input type="checkbox"/> Death in family |
| <input type="checkbox"/> Divorce/separation of parents | <input type="checkbox"/> Recent move |
| <input type="checkbox"/> Serious illness of parent, child, sibling | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Birth of new child | <input type="checkbox"/> Single parent |
| <input type="checkbox"/> Job loss | <input type="checkbox"/> Other _____ |

If yes to "serious illness of parent, child, sibling" please specify:

Please indicate which of the following concerns have been experience in the immediate and/or extended family (parents, siblings, aunts, uncles, cousins, grandparents):

- | | |
|--|--|
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) |
| <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Suicide (threats/attempts/completed) |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Psychiatric Hospitalizations |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease |

If yes to any of the above, specify the relationship to the client:

BACKGROUND INFORMATION

EARLY CHILDHOOD

Please indicate when your child demonstrated each developmental milestone:

Child Walked

- <12 months
- 12-24 months
- 24-36 months
- >36 months
- Has never Walked

Child Spoke Words

- <12 months
- 12-24 months
- 24-36 months
- >36 months
- Has never Spoke Words

Child Spoke Sentences

- <12 months
- 12-24 months
- 24-36 months
- >36 months
- Has never Spoke Sentences

Child First Trained for Urination

- <12 months
- 12-24 months
- 24-36 months
- >36 months
- Not Trained Yet

Child First Trained for Bowels

- <12 months
- 12-24 months
- 24-36 months
- >36 months
- Not Trained Yet

Since Initial Toilet Training

- Frequent wetting during the day
- Frequent wetting during the night
- Frequent soiling during the day
- Frequent soiling during the night
- Not Trained Yet

PUBERTY

Onset of puberty*

- <10 years
- 10-12 years
- 12-14 years
- 14-16 years
- >16 years
- Not Yet Developed

*(breast development, menstruation, pubic hair, facial hair)

EDUCATIONAL

If you have any educational concerns, please bring copies of report cards to visit.

List all schools your child has attended, beginning with the most recent:

Has your child ever repeated a grade: ____ If yes, what was the reason?: _____

Has your child ever had problems in school?: _____ If so, describe: _____

Please indicate where your child is performing academically:

	Below Grade Level	On Grade Level	Above Grade Level
Language Arts			
Mathematics			
Writing			

Does your child enjoy attending school: ____ If no, please explain: _____

Has your child ever been referred for educational interventions, such as additional academic assistance, behavioral management plans, etc.?:

If yes, please describe: _____

Is your child currently on a 504 plan?: _____

If yes, what is your child's diagnosis and the 504 Plan intervention: _____

Is your child currently in Special Education?: _____

Date of most recent IEP: _____

Educational Disability: _____

Services Receiving: _____

Do you feel the interventions (informal/504/Special Education) are effective?: _____

If no, please explain: _____

FAMILY/HOME ENVIRONMENT

Please list all those living in the child's home (relationship, date of birth, occupation/school grade):

Please list other persons closely involved with the child but not living in the child's home (i.e. older siblings, grandparents, sitters, teachers, etc.) Please list frequency of visits.:

If child is not living with both biological parents, is either parent deceased?: _____ If so, please specify:

Were biological parents married?:

Are biological parents divorced/separated?: _____ If so, when?:

Which parent has custody?:

How often does non-custodial parent visit?:

How long have you lived at the current address?:

How often have you changed residences since the birth of the child?:

Does the child share a bedroom?: _____ If so, with whom?:

Does your child have difficulty with siblings?: _____ If yes, please explain:

Was the child ever placed or boarded away from the family?: _____ If yes, indicate reason for placement, where, and with whom?: _____

Has your child ever had difficulty or contact with legal authorities (Police, Juvenile Justice)?:
_____ If yes, please describe circumstances?:

Please describe any religious or cultural beliefs you would like incorporated into your child's treatment: _____

ACADEMIC/BEHAVIORAL CHECKLIST

Please indicate if your child is currently exhibiting difficulty with any of the following:

Reading – Basic Skills

- Difficulty recognizing letters
- Difficulty reciting the alphabet
- Difficulty reading aloud (loses place or skips words)
- Dislikes reading/reluctant to read
- Reads slowly

Reading – Comprehension

- Difficulty understanding the meaning of words
- Difficulty understanding the meaning of passages
- Difficulty identifying main idea
- Difficulty drawing conclusions
- Difficulty following written directions
- Difficulty understanding idioms or figurative language

Math Calculation

- Difficulty identifying numerals
- Difficulty counting by rote
- Difficulty understanding basic arithmetic facts
- Difficulty completing problems involving basic calculation
- Difficulty completing problems involving fractions or decimals
- Difficulty completing problems involving geometric shapes
- Difficulty completing problems with more than one step

Math Reasoning

- Difficulty understanding concepts related to size, sequence or quantity
- Difficulty identifying and using appropriate problem-solving strategies
- Difficulty solving word problems
- Difficulty completing problems involving estimation or prediction
- Difficulty understanding charts, tables, and graphs
- Difficulty generalizing math skills to other types of problems or tasks
- Difficulty understanding abstract mathematical concepts

Written Expression

- Difficulty writing information dictated by others
- Difficulty with basic mechanics of writing
- Confused the order of words in sentences
- Writes in incomplete sentences
- Uses simplistic language when writing
- Difficulty expressing ideas in writing
- Dislikes/avoids written tasks
- Poor handwriting (difficulty with letter formation, poor spacing between letters and words)
- Difficulty copying from blackboard

Oral Expression

- Confuses or leaves out speech sounds
- Disfluency (unusual pauses or repetitions, frequent rephrasing, poor verbal organization)
- Grammatical problems (incorrect use of plurals, verb tense forms, pronouns, etc.)
- Limited vocabulary
- Word retrieval problems
- Problems with social language (initiating conversations, expressing thoughts and feelings, asking questions, etc.)
- Does not speak in class to teachers/students

Listening Comprehension

- Difficulty following oral directions
- Frequently asks or repetition of oral instructions
- Misunderstands spoken word
- Easily distracted by noises or other sounds
- Exhibits short attention span during auditory tasks
- Confuses similar words
- Difficulty understanding sentences that are long or complex
- Cannot repeat information that was just spoken
- Appears disinterested in audio information (tapes, recordings, etc.)
- Demonstrates disruptive or off-task behaviors when required to listen
- Difficulty responding to questions within expected time limits

Social Behaviors

- Misinterprets facial expressions or body language
- Overreacts to perceived insults
- Does not understand teasing, sarcasm, jokes
- Has few or no friends
- Displays attention-getting behaviors, acts like “class clown”
- Misinterprets tone of voice
- Isolated from others – few group or social interactions
- Withdrawn – does not make eye contact, seems introverted, does not participate in discussions

Other Behaviors

- Excessively out of seat
- Refuses to comply with requests
- Withdrawn
- Interrupts others when speaking
- Uses foul language
- Frequently fights with peers
- Engages in risky behaviors
- Associates with children that have been in trouble
- Difficulty focusing
- Poorly organized
- Experiences difficulty starting tasks
- Acts before thinking
- Can't sit still
- Experiences difficulty planning

Comments:

HEALTH INSURANCE

I certify that I, and/or my dependent(s) have insurance coverage with

_____ (name of insurance) and assign directly to Rita Vatcher, LMHC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Rita Vatcher, LMHC may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I understand that if I have a co-payment with my insurance plan, payment is expected at the time of service by check, cash, or credit card (Visa or MasterCard). **If my insurance plan does not cover a session, I am responsible for payment of these charges at a rate of \$140 per contact hour.**

Please note, verification of benefits does not guarantee payment of a claim in full. If Rita Vatcher, LMHC is an out-of-network provider in my plan, I am responsible for payment at the time of service and it is my responsibility to submit paperwork to my insurance provider for reimbursement directly to me. This consent will end one year from the date signed below.

Client/Parent/Legal Guardian Signature _____ Date: _____

If applicable, please provide the following insurance information:

Name of the Insurance Subscriber: _____

Subscriber's DOB: _____

Subscriber ID #: _____

Subscriber Group #: _____

Ins. Phone # for Mental Health Benefits: _____

Ins. Phone # for Medical Health Benefits: _____

Name of employer or other entity where health plan is obtained: _____

Is your health insurance plan either: a union plan, employer self-funded plan, or a trust plan?:

_____ If yes, please provide plan contact name and phone #:

CANCELLATION POLICY

24-hour notice is required for cancellation, except in the case of sudden illness. Otherwise, missed appointments must be paid in full.

Client/Parent/Legal Guardian Signature _____ Date: _____

PERMISSION TO TREAT A MINOR:

As legal guardian for _____, I hereby give permission for this minor to receive counseling services from Rita Vatcher, LMHC.

Permission to treat does not dismiss the rights of the minor from protection under the Federal Confidentiality guidelines. Any release of information form must contain the signature of both the minor and the guardian in order to be valid.

Signature: _____ Clinician: _____

Date: _____