



Freedman & Associates

Mental Health Services for Children & Families

1513 E Street, Bellingham, WA 98225

phone: 360-734-2664

fax: 360-671-8006

CHILD AND FAMILY INTAKE FORM

Please complete all pages of form.

Child's Full Name: _____ Social Security#: _____

Date of Birth: _____ Gender: MALE FEMALE

Referred by: _____ Primary Care Physician: _____

Child lives with: Mother Father Both Other: _____

Mother's Name: _____ Social Security#: _____

Father's Name: _____ Social Security#: _____

Child's Address: _____

Home Phone: _____ day evening OK to leave msg? YES NO

Work Phone: _____ day evening OK to leave msg? YES NO

Cell Phone: _____ day evening OK to leave msg? YES NO

PRIMARY INSURANCE INFORMATION

(information found on insurance card)

Insurance Company: _____ Phone#: _____

Insurance Company Address: _____

Subscriber's Name: _____ Relationship to client: _____

ID#: _____ Group/Plan #: _____

SECONDARY INSURANCE INFORMATION

(information found on insurance card)

Insurance Company: _____ Phone#: _____

Insurance Company Address: _____

Subscriber's Name: _____ Relationship to client: _____

ID#: _____ Group/Plan #: _____

COUNSELOR'S NOTES (for office use only)

Date	Dx code	dx	Provider Signature

CHILD'S MEDICAL HISTORY

How is your child's general health? Excellent Good Fair Poor

Briefly describe your primary concerns and why you have brought your child to the office:

When was your child's last comprehensive medical evaluation? _____

Has your child ever been hospitalized for psychological reasons? Yes No

If yes, when and where? _____

Please check whether your child currently has, or has ever had any of the following:

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> drug/alcohol abuse | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> changes in appetite | <input type="checkbox"/> flashbacks |
| <input type="checkbox"/> running away | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> epilepsy or seizures | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> disturbing thoughts | <input type="checkbox"/> lack of interest | <input type="checkbox"/> sexual abuse | <input type="checkbox"/> depression |
| <input type="checkbox"/> memory problems | <input type="checkbox"/> low self-esteem | <input type="checkbox"/> speech problems | <input type="checkbox"/> confusion |
| <input type="checkbox"/> irritability | <input type="checkbox"/> emotional abuse | <input type="checkbox"/> hearing problems | <input type="checkbox"/> stress |
| <input type="checkbox"/> bowel problems | <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> visual problems | <input type="checkbox"/> bedwetting |
| <input type="checkbox"/> suicidal ideations/attempts | <input type="checkbox"/> feelings of hopelessness | <input type="checkbox"/> homicidal thoughts | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> sexual concerns | <input type="checkbox"/> difficulty managing anger | <input type="checkbox"/> asthma | <input type="checkbox"/> head trauma |
| <input type="checkbox"/> chronic illnesses | <input type="checkbox"/> family/relationship issues | <input type="checkbox"/> communication problems | <input type="checkbox"/> mood swings |
| <input type="checkbox"/> phobias: _____ | <input type="checkbox"/> hormone disorder | <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> physical abuse or neglect | <input type="checkbox"/> panic attacks | <input type="checkbox"/> serious infection | <input type="checkbox"/> allergies |
| <input type="checkbox"/> racing thoughts | <input type="checkbox"/> frequent stomachaches | <input type="checkbox"/> feelings or paranoia | |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> school/work difficulties | <input type="checkbox"/> blood pressure concerns | |
| <input type="checkbox"/> problems with coordination | <input type="checkbox"/> frequent or uncontrolled crying | <input type="checkbox"/> self-destructive or self-injurious behavior | |
| <input type="checkbox"/> Other physical or emotional issues (please describe): | | | |
-
-

Is your child currently taking medication? Yes No

Medication: _____ Dosage: _____ Date Started: _____

Medication: _____ Dosage: _____ Date Started: _____

Medication: _____ Dosage: _____ Date Started: _____

List any serious illnesses for which the child required hospitalization or surgical operation:

Illness	Year	Doctor	Hospital

