



Freedman & Associates

# Mental Health Services for Children, Adolescents & Adults

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## CHILD AND FAMILY INTAKE FORM

Please complete all pages of form.

Today's Date: \_\_\_\_\_  
Child's Full Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender:  MALE  FEMALE  
Referred by: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Child lives with:  Both  Mother  Father  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: \_\_\_\_\_  
Subscriber's Address: \_\_\_\_\_  
ID#: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION (information found on insurance card)

Insurance Company: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_  
Subscriber's Address: \_\_\_\_\_  
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:

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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): |  |  |                                      |

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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

Has your child ever received psychological, substance abuse, or psychiatric services?

Service	Year	Doctor	Issue at Time

**FAMILY SITUATION**

Relationship/Marital Status of parents:     Single         Involved         Engaged         Cohabiting  
     Remarried         Married         Separated         Divorced         Widowed

Names and ages of other adults & children residing in the home:

Name	Age	Relationship to Client

**Mother's-**

Educational Level (Circle):    8      9      10      11      12      13      14      15      16      17      18      19+

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ For how long? \_\_\_\_\_

**Father's-**

Educational Level (Circle):    8      9      10      11      12      13      14      15      16      17      18      19+

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ For how long? \_\_\_\_\_

Are there any family members experiencing significant medical problems or substance abuse?

**(Please indicate relationship to child):**

Medical Problems-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Alcohol Use-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Drug Use-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Tobacco Use-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Caffeine Use-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Has your child had previous counseling?     Yes         No

If yes, with whom? \_\_\_\_\_ When? \_\_\_\_\_

Would it help to contact the previous counselor(s)?     Yes         No

**GOALS FOR THERAPY**

What are the goals and outcomes you would like to achieve for your self/child with therapy?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_