NEW HOPE
COUNSELING CENTER

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*35037 Royal Place * Soldotna, AK 99669 * (907) 260-7423*

CLIENT INFORMATION FORM
Child 0-12

General Information

Name of child: ______________________________

Name of Person Completing Form: ________________Relationship to Child: ____________

Child's date of birth: ______________ Child's age_____ Child's gender___________________

Child's mailing address: ____

Name of parent or guardian: ____

Parent or guardian's address: ____

Parent's work phone: ___________Home phone: ______________ Cell:________________

A confidential phone number to reach you: ___________

Child's home phone: ______________Child's cell phone: ___________________________

Emergency Contact Name:________________Phone:______________________________

Primary Insurance Information

Child's relationship to insured: ____Self ____ Other

Insurance Policy Holder: ____________________

Policy Holder Date of Birth: ___________________

Policy Holder Mailing Address: ________________

Policy Holder Employer: _____________________

Insurance Company Name: __________________

Insurance ID#: ____________________________

Group #: ________________________________

Secondary Insurance Information

Child's relationship to insured: ____Self ____ Other

Insurance Policy Holder: ____________________

Policy Holder Date of Birth: ___________________

Policy Holder Mailing Address: ________________

Policy Holder Employer: _____________________

Insurance Company Name: __________________

Insurance ID#: ____________________________

Group #: ________________________________

MULTIPLE INSURANCE COVERAGE *– For those with more than one insurance coverage, due to cost and time constraints,* ***we are only able to bill your primary insurance****. However, we will be happy to assist you by providing you information so that you may submit a claim to your secondary insurance company.* ***Should Secondary Insurance Companies only submit checks to NHCC, we will reimburse clients once ALL Secondary Insurance funding has been received****.*

Please remember that insurance is a contract between you and your insurer. We are happy to help as much as we can to ensure payment of your benefits, however, we cannot, and will not become involved in disputes concerning deductibles, co-payments, secondary insurance, or what insurance companies refer to as, "usual and customary" reductions (initial _____).

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Employee Assistance Program (EAP) Information

EAP Employer Name: _______________________________ EAP Provider Name: _______________________

Number of Sessions: _________ Approval Code/Conformation#: ____________________________________

EMPLOYEE ASSITANCE PROGRAMS (EAP) - *New Hope Counseling Center counselors are credentialed with many Employee Assistance Programs. In order to utilize this service, you must provide the NHCC Office Administrator with the name of the EAP and the authorization number* ***on or before the first visit****. If verification is not provided by the first appointment, then your private insurance company will be billed at the full intake hourly rate. If you are not insured, the administrative discount for paying out of pocket will apply, and you will be responsible for payment at time of service. (initial ____.)*

Other Compensation

Is the child's condition related to:

1.. *Auto Accident?* ___Yes ___No 2. *Other Accident?* ___Yes ___No

If yes to any of the above,
Date and Location of Claim: ____
____

I understand that payment for all treatment received for my child is my responsibility. I hereby authorize the release of any information to my insurance company that is required to process a claim on my behalf, including, but limited to, insurance appeal rights on my behalf. I also herby authorize my insurance company to remit payment for any behavioral health benefits due directly to New Hope Counseling Center. These authorizations shall expire in one year, or upon my written notice.

Signature of Responsible Party: ______________________________________ **Date:** _______________________

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Child Intake 0-12

In order for us to best serve you, it is extremely helpful if we have some background information regarding your child's situation. Please answer all questions to the best of your ability.

ALL INFORMATION IS HELD IN THE STRICTEST OF CONFIDENCE

Child's Name: ____________________________ **Child's Birthdate**: __________________

Child's Family History

Who does the child currently live with? ____
Child's birth order: (circle) 1 2 3 4 5 6 7
Ages of siblings ___ ___ ___ ___ ___ ___ ___
Religious Preference: ____
Cultural background:/Cultural Concerns: ____
Has the child been separated from his biological father or mother? ____________________________
If yes, for how long and under what circumstances:____
____

Child's Developmental History

While pregnant, mother used: ___N/A ___Alcohol ___Drugs ___Both

Developmental milestones of walking, talking, toilet training, & reading were:
___Early ___On Time ___Delayed

Child is predominately: ___Right Handed ___Left Handed

Child's Social History

How many close friends does your child have? ____ If possible give names(s), age(s), gender(s), and their relationship. (i.e. school friend, teammate, neighbor, etc.)
____
____
____
Does your child prefer to play alone or with others? _____________________________________
What are your child's interests, hobbies, and recreational activities? _____________________________
____

Academic History

Child started school: ___Early ___On Time ___Late
Current grade:__ ______ Current school: ____
Primary teacher (if applicable): ________________ School Counselor: ___________________________
Please list past schools: ____

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Has your child ever had academic problems or advanced a grade? Yes ___ No ____
If yes, please describe: ____

____

____

How is your child currently performing in the following areas? (i.e. A, B, C, D, F)
___Math ___Science ___Reading ___Writing ___English ___Social Science
___History ___Physical Education

What behavioral problems, if any, has your child had in school? (please check)
___None
___Truancy Please describe: ____________________________________
___Fighting Please describe: ____________________________________
___Uncooperative Please describe: ____________________________________
___Other Please describe: ____________________________________

Medical History

Name of child's current physician: _____________________ Phone _____________________________
Date of last examination or physical: ____
Name of Physician who does medication management (if any)? _______________ Phone: __________

Has your child ever been hospitalized? ___Yes ___No If yes, please describe all occurrences and reasons: ____

____

____

Does your child have any of the following medical conditions?

___Anemia	___Asthma	___AIDS/HIV
___Allergies	___Brain injuries	___Cancer
___Colic	___Dizziness	___Ear infections
___Headaches	___Head injuries	___Hearing Problems
___High Fever	___Influenza	___Pneumonia
___Seizures	___Skin problems	___Tuberculosis
___Vision	___Other	

Please briefly describe any checked medical conditions: _____________________________________

____

____

____

Current prescribed medication(s) for medical or mental health conditions:

____

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Medication	Dosage	Date	Reason

Prior Medications for treatment of mental health issues?

Medication	Approximate Length of Use	Date	Effective?

List any diets or exercise programs: ____
List any other medical problems and associated medications: ______________________________________
____

Substance Use

History of substance use: Yes ___No ___ Current: Yes ___ No ___
Substances: ____
Frequency: _________________________Amount: ___________________________________
Longest period of sobriety: _______________ Length of use: ____________________________
Prior Treatment: ____

Predominant Mood: (pick all that apply) __anxious __depressed __happy
__sad __fearful __manic __just so-so __flat

Appetite: __good __poor __fair __intense

Weight: __stable __loss __binging __binging/purging __gain

Experience of: __moderate exercise __pleasurable activities
__pre-occupation with pleasurable activities __inability to have fun
__diminished interest in activities

Sleep: ___number of hours/night ___restful ___unrestful

Waking up: ___frequent ___infrequent ___very infrequent
___mid-sleep disruption ___late or early disruption

Experience of: ___nightmares ___night terrors ___repeating dreams
___recurrent nightmares ___insomnia ___euphoria ___extended agitation

Reports being watched __Yes __No
Reports hearing voices when no one is around __Yes __No

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Reports faces appear distorted __Yes __No
Reports colors appear to be bright or faded __Yes __No
Has the child ever attempted suicide? __Yes __No

Legal History

Has your child ever had any legal problems? ______ If yes, please describe when it occurred, where it occurred, and what happened:____
Does your child have a probation officer?
If yes, please provide Name of probation officer: ______________________ Phone:________________

3-Object Recall (completed with counselor: ____) W-O-R-L-D (completed with counselor: ____)

Rate the items with which your child is currently having problems. Circle the number that best indicates the existence or severity of the problem.

0=none 1=minor 2=moderate 3=significant 4=serious

Circle the word or words that best define each statement:

Anxiety: (worry) (fear) (panic) (phobia)	0 1 2 3 4
Feelings of: (depression) (sadness)	0 1 2 3 4
Thoughts of: (death) (suicide)	0 1 2 3 4
Sleep Disturbances	0 1 2 3 4
Mood Swings	0 1 2 3 4
Issues related to: (pregnancy) (abortion)	0 1 2 3 4
Sexual abuse: (incest) (rape)	0 1 2 3 4
Parental problems with: (alcohol) (drugs)	0 1 2 3 4
Problems with: (siblings) (parents) (friends)	0 1 2 3 4
Sexual: (concerns) (problems)	0 1 2 3 4
Problems with: (alcohol) (drugs) (smoking)	0 1 2 3 4
Feelings of: (hopelessness) (helplessness) (despair)	0 1 2 3 4
Memory: (forgetfulness) (changes)	0 1 2 3 4

State in your own words what has brought your child to counseling:
____
____
____

To the best of my knowledge, the information provided is accurate and true.

Signature: ________________________________ **Date:** ______________________________________