

INTAKE FORM (Child/Adolescent)

PERSONAL INFORMATION

Child's Name _____ Responsible Party _____
 Address _____ Address (if different) _____
 _____ Zip _____ Zip _____
 Phone (H) _____ (W) _____ Phone (H) _____ (W) _____
 Cell _____ May we contact you by phone? Y N

FAMILY INFORMATION (continue on back if necessary)

NAMES	M/F	AGE	BIRTH DATE	EDUCATION	OCCUPATION
Client:					
Father (Stepfather):					
Mother (Stepmother):					
Siblings:					
1.					
2.					
3.					

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder _____
 Address (if different) _____

 Insurance Company _____
 Address _____

 Phone _____
 Policy Holder's Member # _____
 Group # _____
 Employer _____
 Employer's Address _____

SECONDARY INSURANCE

Policy Holder _____
 Address (if different) _____

 Insurance Company _____
 Address _____

 Phone _____
 Policy Holder's Member # _____
 Group # _____
 Employer _____
 Employer's Address _____

MEDICAL INFORMATION

Physician _____ Phone# _____

Describe any health problems child has. _____

What medications does child take? _____

What serious illnesses has child had? _____

List any prior surgeries. _____

Has child had prior counseling or therapy? Y N When? _____

What was the concern? _____

Who was the counselor? _____

Has child ever been hospitalized for psychiatric treatment? Y N When? _____

Where was child hospitalized? _____ For how long? _____

What brings you to counseling now? _____

How long have the current problems existed? _____

Describe your present concerns: (Circle one) Mild Moderate Moderately Severe Severe A Crisis

How did you learn about us? _____

Emergency Contact Person _____
(Name) (Relationship) (Phone)

PLEASE MARK ALL THAT APPLY:

- | | | |
|---|---|---|
| <input type="checkbox"/> crying spells | <input type="checkbox"/> panic attacks | <input type="checkbox"/> relationship concerns |
| <input type="checkbox"/> unable to have fun | <input type="checkbox"/> truancy | <input type="checkbox"/> work difficulties |
| <input type="checkbox"/> feelings easily hurt | <input type="checkbox"/> school suspensions | <input type="checkbox"/> sexual acting out |
| <input type="checkbox"/> lacking in confidence | <input type="checkbox"/> defiant toward authorities | <input type="checkbox"/> |
| <input type="checkbox"/> constipation | <input type="checkbox"/> disobedient | <input type="checkbox"/> |
| <input type="checkbox"/> acts irritable | <input type="checkbox"/> stomach trouble | <input type="checkbox"/> |
| <input type="checkbox"/> always tired | <input type="checkbox"/> nightmares | <input type="checkbox"/> excessive medication use |
| <input type="checkbox"/> poor appetite | <input type="checkbox"/> feeling tense | <input type="checkbox"/> excessive drug use |
| <input type="checkbox"/> seems depressed | <input type="checkbox"/> cold feet and hands | <input type="checkbox"/> problems with siblings |
| <input type="checkbox"/> trouble sleeping | <input type="checkbox"/> feeling panicky | <input type="checkbox"/> problems with parents |
| <input type="checkbox"/> seems to feel lonely | <input type="checkbox"/> diarrhea | <input type="checkbox"/> poor physical health |
| <input type="checkbox"/> loss of weight | <input type="checkbox"/> shy with people | <input type="checkbox"/> fighting and quarreling |
| <input type="checkbox"/> not enjoying things | <input type="checkbox"/> muscle twitching | <input type="checkbox"/> dislike my body |
| <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> nausea or vomiting | <input type="checkbox"/> full of energy |
| <input type="checkbox"/> feeling inferior | <input type="checkbox"/> can't make decisions | <input type="checkbox"/> overly ambitious |
| <input type="checkbox"/> worries or is anxious | <input type="checkbox"/> can't make friends | <input type="checkbox"/> easily excited |
| <input type="checkbox"/> says "no one understands me" | <input type="checkbox"/> headaches | <input type="checkbox"/> quick tempered |
| <input type="checkbox"/> worried about health | <input type="checkbox"/> fainting spells | <input type="checkbox"/> impatient with people |
| <input type="checkbox"/> can't concentrate | <input type="checkbox"/> unable to relax | <input type="checkbox"/> binge eating |
| <input type="checkbox"/> can't "get going" | <input type="checkbox"/> feeling fearful | <input type="checkbox"/> very restless |
| <input type="checkbox"/> seems angry | <input type="checkbox"/> overly sensitive | <input type="checkbox"/> physically aggressive |
| <input type="checkbox"/> doesn't like being alone | <input type="checkbox"/> poor social skills | <input type="checkbox"/> destroys property |
| <input type="checkbox"/> lacks energy | <input type="checkbox"/> weight gain | <input type="checkbox"/> excessive overeating |

DUTCH FORK PSYCHOLOGICAL SERVICES, LLC

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We welcome to our practice and we look forward to working with you. We believe the following information will be helpful in establishing a good therapy relationship between us. Please read this information carefully, and ask any questions you may have. When you have read both pages, please sign the statement below.

Professional Background Bill Haxton, Ph.D. is a Licensed Clinical Psychologist (#654), having earned a Doctorate in Clinical Psychology from Georgia State University in Atlanta where he specialized in child and family psychology and developmental neuropsychology. Dr. Haxton earned his undergraduate degree in Psychology at the University of North Carolina at Chapel Hill, and a master's degree in Counseling at Trinity Evangelical Divinity School in Chicago. He completed his clinical residency at the Medical College of Georgia. Dr. Haxton is a member of the South Carolina Psychological Association and the American Psychological Association. He has over 20 years experience working children, adolescents, and adults.

Beth Nowell-Haxton, Ph.D. is a Licensed Clinical Psychologist (#700) who completed her Doctoral degree at the University of Tennessee in Knoxville and her clinical residency at the Medical College of Georgia. She earned her undergraduate degree in Psychology at the University of Tennessee, Knoxville. With over 15 years of clinical experience, her background includes the treatment of children, adolescents, and adults using a variety of assessment and counseling techniques. Dr. Nowell-Haxton is a member of the South Carolina Psychological Association and the American Psychological Association.

Initial Appointment The initial appointment is considered a diagnostic interview. From the information shared with me on this first visit, we will decide together whether I am the right therapist to help you attain your goals. If we decide to work together, we will discuss the type of therapy needed (individual, couple, family, etc.), the frequency of therapy sessions (weekly, bi-weekly, etc.), and schedule your next appointments.

Appointments Each therapy session lasts 45-50 minutes. All appointments are scheduled directly with me, in person or by phone. If you find that you need to cancel an appointment, please give as much notice as possible. You will be personally charged for appointments not canceled at least 24 hours in advance, except for emergency reasons. Insurance companies do not pay for unattended appointments.

Payments The fee for your initial visit is \$150 and for each therapy session thereafter is \$125. (The fee for psychological evaluations is contracted separately.) Most insurance companies will pay for a portion of outpatient mental health services. With your approval by signature, I will bill your insurance company, and have the payments sent directly to me. You will be responsible for paying all deductibles and co-pays in full at each visit by cash or check. Because payment for your services is ultimately your financial responsibility, you should check carefully with your insurance company to find out the specific requirements of your coverage.

Minors and Parents

Patients under 18 years of age who are not emancipated, as well as their parents, should be aware that the law allows parents to examine their child's Clinical Records, unless I decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is

often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Termination As you reach your goals in therapy, a gradual tapering of sessions typically occurs. It is helpful for you to discuss your wish to end counseling at least one or two sessions prior to your last session. A final session to process your therapy, settle any unfinished concerns, and say goodbye has proven to be beneficial.

Emergencies Our confidential voicemail (803-407-7099) is always available for leaving messages when I am in session or out of the office. If an emergency arises when I am not available to speak with you, please call the National Lifeline (1-800-273-8255), which provides 24-hour crisis intervention services. The emergency room of the nearest hospital is also another resource in time of crisis.

I encourage you to ask any questions you may have concerning the above policies, either now or as they occur. More comprehensive information is available in our Psychologist-Patient Service Agreement.

Please circle:

YES NO I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

YES NO I have received a copy of this form, the Service Agreement and privacy practices brochure.

YES NO I authorize the release of any medical information necessary to process my insurance claims.

YES NO I authorize benefits to be paid directly to my psychologist or to Dutch Fork Psychological Services, LLC.

YES NO I consent to the exchange of treatment information between my psychologist and my primary care physician.

Signature

Date