Child Intake Form

Northwoods Counseling Services
481 Mag Seven Court SW, Suite #3; Bemidji, MN 56601
Phone: 218-444-2821 Fax: 218-333-9445

Child's name: _____Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female

Your name and relationship to child: _____

Who has current legal guardianship of child: _____

Mail Address: _____Physical Address: _____

City: _____ State: ____ Zip: _____ County: _____ Referral Source: _____

☐Home #_____ ☐Cell #_____ Text OK? ☐Yes ☐ No

Email Address (for client portal/apt reminders): _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ Alaskan/Native American Tribe: _____

INSURANCE INFORMATION: (Present Insurance Card to Office Staff Please)

Primary Insurance Company: _____

Card Holder: _____ Birth date:_____

Phone #: _____ Employer: _____

Address _____

Employer _____

Policy ID #_____ Group # _____

Client Lives: ☐ Alone ☐ With immediate family ☐ With extended family ☐ With non-related

Child currently Lives:
☐ at home with family (Names of Parents): _____
☐ at a relative's home (Name and Relationship of custodial adults in this home): _____
☐ in a foster home (Name of foster parents): _____
☐ at a group home or residential facility (Name of Facility):_____

☐ other (please explain):_____
Length of time child has been at current placement? _____

People residing in the same household with child:

Name	Age	Occupation	Relationship to child

Health Current physician: _____ Location: _____

When was your child's last physical examination? _____ Results: _____

Is your child allergic to any drugs? ☐ Yes ☐ No If yes, please list: _____

School Current School/Childcare: _____ Grade: _____

School Contact: _____

In case of emergency, who may we contact?

_____
Name Relationship to Child Phone Number

**I authorize Northwoods Counseling Services Ltd. to release necessary information to my emergency contact in the event of emergency* Initial: _____

Does a copy of your assessment need to be forwarded to someone outside of this office? ☐ Yes ☐ No

If yes, please tell us: Who: _____ Office: _____

This next section is meant to provide your counselor information to help in providing thorough and relevant therapy services, as well as to make the best use of the initial session.

Reason for Referral

Main problems for which services are being sought: _____
_____
_____

Goals you hope to achieve by coming for services: _____

_____
_____

Cultural/Religious Background
Cultural/ethnic/religious beliefs/practices: _____
_____

Does the cultural/ethnic/religious background affect the client's mental health or services? ☐ No ☐ Yes

Mental Health History
Has this client received mental health services in the past? ☐ No ☐ Yes: _____

Is there any history of mental health problems in the family? ☐ No ☐ Yes – please specify below

Family Mental Health History
In the section below identify if any members of your family and extended family have a history of any of the following. If yes, please indicate the family member's relationship to client in the space provided.

	Please Circle		**Relationship to client**
Anxiety	Yes	No	
Obsessive Compulsive Disorder			
Depression			
Suicide Attempts			
Bipolar/Manic Depressive			
Alcoholism/Substance Use			
Eating Disorder			
Schizophrenia			
Psychiatric hospitalizations			

Medical History
Has this client experienced any major illnesses and/or do they have any ongoing medical conditions?
☐ No ☐ Yes:
_____
Any significant family health/medical history? ☐ No ☐ Yes: _____

Current medications, including over-the counter (OTC) items taken: ☐ No Current Medications

Medication	Dosage	Provider/OTC

High caffeine use for client: ☐ No ☐ Yes: _____

Drug/alcohol/tobacco use concerns for client: ☐ No ☐ Yes: _____

History of drug/alcohol abuse in the family: ☐ No ☐ Yes: _____

Educational History

Attendance: ☐ Rarely Absent ☐ Sometimes Absent ☐ Frequently Absent
Academic Abilities: ☐ Above Average ☐ Average ☐ Below Average

Peer Relations: ☐ Above Average ☐ Average ☐ Below Average

Behavior: ☐ Above Average ☐ Average ☐ Below Average

Has this child been tested for special education: ☐ No ☐ Yes Disability if known: _____

Does this child have a current IEP: ☐ No ☐ Yes

Current Living Environment

☐ Comfortable ☐ Supportive
☐ Chaotic ☐ Abusive
☐ Positive family relationships
☐ Family relational problems
☐ Home in good repair ☐ Home needs repair
☐ Safe neighborhood
☐ Safety concerns in the neighborhood
☐ Financially stable ☐ Financially stressed

Comments:_____

Pregnancy/Development

Complications during the pregnancy: ☐ No ☐ Yes: _____

Substance use during the pregnancy: ☐ No ☐ Yes Tobacco use during the pregnancy: ☐ No ☐ Yes

Length of Pregnancy: ☐ Full Term ☐ Premature Birth: _____

Complications during delivery: ☐ No ☐ Yes

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Master of Developmental Milestones	Early	Average	Delayed
Rolling Over	☐	☐	☐
Crawling	☐	☐	☐
Walking	☐	☐	☐
First Words	☐	☐	☐

Has the client experienced any of the following?
Sleep problems: ☐ No ☐ Yes Comments: _____
Feeding/eating problems: ☐ No ☐ Yes Comments: _____
Hearing/vision problems: ☐ No ☐ Yes Comments: _____
Social problems: ☐ No ☐ Yes Comments: _____
Out of home placement: ☐ No ☐ Yes Comments: _____

How much are each of the following areas currently a problem for your child?

	Not at all	**A little**	**Somewhat**	**Considerably**	**Terribly**
Anxiety					
Physical problems					
Sleep problems					
Depression					
Alcohol or substance use					
Parent-child conflicts					
Sibling conflicts					
Social relationships					
School difficulties					
Spiritual/religious					
Legal concerns					
Eating disorder					
Abuse (physical, emotional, sexual)					

Completed by: _____ Relationship to Client: _____

BILLING INFORMATION – Please read and sign:

1. I authorize Northwoods Counseling Services Ltd to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, agency accountant(s), agency legal representatives, RPT-S Supervisor, and insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize Northwoods Counseling Services to release my medical records and billing information to my Primary Care and/or Referring Physician.
3. I authorize my insurance benefits to be paid to Northwoods Counseling Services
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.

Name of person completing this form (please print) _____

Signature of person completing this form_____ Date: _____

Relationship to Patient: _____

PERMISSION TO PROVIDE TREATMENT

I, _____, hereby authorize Northwoods Counseling

Services Ltd to provide psychotherapy services. I attest to the fact that I have the legal authority to grant this permission.

Signature: _____ Date: _____

Cancellation Policy/Agreement

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Due to high demand for mental health services at Northwoods Counseling Services Ltd., clients and families are being asked to sign, and agree to, the cancellation policy terms and conditions. Text Message reminders 24 hours prior containing the appointment date and time are a courtesy provided by Northwoods Counseling Services Ltd. to ensure attendance. Please request this service if you do not currently receive text message reminders.
Late Cancel/No Shows: If patients arrive 15 or more minutes late to an appointment without calling to inform Northwoods Counseling Services Ltd. of the late arrival, they may be asked to reschedule as their appointment will be considered a Late Cancel/ No Show. Patients unable to attend a scheduled appointment or group session must cancel the appointment more than 24 hours prior to the appointment time. Reminder text messages are sent at this time. To cancel an appointment, please text or call 218-252-2785. In cases of extraordinary circumstances that arise less than 24 hours prior to the appointment time (e.g. physical illness), the clinic still appreciates to be informed about the missed appointment. There is a daily cancellation list of patients hoping to attend an open appointment time. It is appreciated by other clients and their families if you call with enough time to allow their attendance at that time. This also ensures the possibility of an appointment opening to reschedule your appointment at a later date. Failure to cancel an appointment less than 24 hours prior to an appointment will require:

- One late cancel/no show in a six month period= Client must call to confirm an appointment the following week. If no call is made, no appointment will be made for the following week.
- Two late cancels/no shows in a six month period= Client will lose their weekly/ biweekly session time and must schedule an appointment each week.
- Three late cancels/no shows in a six month period= Client will be required to call the morning of the day the client prefers to attend an appointment. A session will be scheduled if an appointment time is available. If no time is available, the client will need to call back at a later date.

I understand and agree to the above cancellation policy.

Signature:_____ Date: _____

Printed Name: _____

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