christianlife counseling, LLC

CHILD INTAKE

PARENT INFORMATION

FATHER INFORMATION		MOTHER INFORMATION	
NAME		NAME	
PREFERRED NAME		PREFERRED NAME	
DATE OF BIRTH		DATE OF BIRTH	
ADDRESS		ADDRESS	
CITY, ZIP		CITY, ZIP	
MOBILE PHONE		MOBILE PHONE	
HOME PHONE		HOME PHONE	
EMAIL		EMAIL	
EMPLOYER		EMPLOYER	
OCCUPATION		OCCUPATION	
INSURANCE			
POLICY HOLDER			
EMERGENCY CONTACT			
CONTACT PHONE			

CHILD INFORMATION

CHILD'S NAME		PREFERRED NAME	
SEX		DATE OF BIRTH	
ADDRESS		CITY, ZIP	
CHILD'S BIRTHPLACE		ETHNICITY	
PERSON COMPLETING THIS FORM		RELATIONSHIP TO CHILD	

PLEASE RETURN TO CHRISTIAN LIFE COUNSELING @ 12630 W NORTH AVE, BLDG E BROOKFIELD, WI 53005-4626

CHILD'S PRIMARY RESIDENCE

SINGLE PARENT HOME _____ TWO PARENT HOME _____ OTHER _____

CUSTODY

SOLE _____ JOINT _____

MARITAL STATUS OF THE PRIMARY CAREGIVER (PLEASE PROVIDE THE DATE)

MARRIED _____ DIVORCED _____ SEPARATED _____

MOTHER REMARRIED _____

FATHER REMARRIED _____

OTHER CHILDREN (LIVING WITH THIS CHILD, INDICATE IF HALF OR STEP SIBLING)

NAME/RELATIONSHIP _____ AGE _____

NAME/RELATIONSHIP _____ AGE _____

NAME/RELATIONSHIP _____ AGE _____

NAME/RELATIONSHIP _____ AGE _____

NAME/RELATIONSHIP _____ AGE _____

OTHER RELATIVES IN THE HOME

_____

_____

_____

IS YOUR CHILD ADOPTED? YES NO

IF SO, PLEASE DESCRIBE THE CIRCUMSTANCES OF THE ADOPTION

_____

_____

_____

_____

_____

PLEASE DESCRIBE YOUR CONCERNS FOR YOUR CHILD

HAS YOUR CHILD EVER RECEIVED INPATIENT OR OUTPATIENT TREATMENT? YES NO

IF YES, PLEASE LIST (IN ORDER) INCLUDING ORGANIZATION AND/OR NAMES OF PROFESSIONALS

SCHOOL INFORMATION

CURRENT SCHOOL _____ PHONE NUMBER _____

NAME OF TEACHER _____ GRADE _____

LIST PREVIOUS SCHOOLS ATTENDED, ALONG WITH DATES AND OVERALL PERFORMANCE

SCHOOL _____ PERFORMANCE POOR FAIR GOOD

SCHOOL _____ PERFORMANCE POOR FAIR GOOD

SCHOOL _____ PERFORMANCE POOR FAIR GOOD

SCHOOL _____ PERFORMANCE POOR FAIR GOOD

GRADE(S) REPEATED _____ GRADE(S) SKIPPED _____ EXPELLED _____

IF EXPELLED, PLEASE EXPLAIN _____

HAS YOUR CHILD BEEN DIAGNOSED WITH ANY LEARNING DISABILITIES? YES NO

IF SO, PLEASE PROVIDE WHICH AND BY WHOM HE/SHE WAS DIAGNOSED

IS YOUR CHILD IN ANY SPECIAL PROGRAMS (SPEECH, READING, ETC.)? YES NO

IF SO, PLEASE EXPLAIN

HOW DO TEACHERS DESCRIBE THIS CHILD'S CLASSROOM BEHAVIOR?

WHAT DOES YOUR CHILD DO BEST IN SCHOOL?

WHICH OF THE FOLLOWING PROBLEMS, IF ANY, DOES YOUR CHILD HAVE IN SCHOOL?

DOES NOT DO HOMEWORK	____	STARTS BUT DOES NOT FINISH HOMEWORK	____	FAILS TO CHECK HOMEWORK	____
FORGETS ASSIGNMENTS	____	POOR READING	____	POOR HANDWRITING	____
POOR SPELLING	____	DISTRACTED	____	MESSY/DISORGANIZED	____
DOES NOT REMAIN SEATED	____	INCOMPLETE CLASSROOM WORK	____	POOR ATTENTION IN CLASS	____
MAKES CARELESS ERRORS	____	PROBLEMS WITH WRITTEN LANGUAGE	____	TEST ANXIETY	____
OTHER					

WHICH OF THE FOLLOWING PROBLEMS, IF ANY, DESCRIBES YOUR CHILD'S INTERACTIONS WITH PEERS?

NO FRIENDS	____	FEW FRIENDS	____	LOSES FRIENDS	____
TROUBLE MAKING FRIENDS	____	MEAN, AGGRESSIVE	____	TOO SHY OR TIMID	____
BOSSY, CONTROLLING	____	RISKY BEHAVIOR	____		
OTHER					

FURTHER COMMENTS ON HOMEWORK, ACADEMIC FUNCTIONS, AND PEER RELATIONS

WHAT DO YOU SEE AS YOUR CHILD'S STRENGTHS?

Medication History

Is your child on any medication?

If so, please list name, dose, diagnosis and person prescribing the medication

Has your child had any surgical procedures?

If so, please describe and provide the date(s)

List any medical illnesses (allergies, chronic illnesses, etc.).

Family Medical History

Do medical illnesses run in the family (seizures, thyroid problems, allergies, etc.)?

If so, please describe and include the person(s) relationship to your child

Therapy History

Does your child have a history of physical or sexual abuse?

If yes, was the abuse previously reported to social services and/or police? If so, provide the date reported and the follow-up action

Has the child ever been in contact with the police?

If so, please describe and provide the date(s)

DOES YOUR CHILD HAVE A HISTORY OF ALCOHOL OR OTHER DRUG USE?

IF SO, PLEASE DESCRIBE

_____

_____

_____

TO YOU KNOWLEDGE, IS YOUR CHILD SEXUALLY ACTIVE? YES NO

HAS YOUR MINOR CHILD'S SEXUAL ACTIVITY BEEN REPORTED TO SOCIAL SERVICES AND/OR POLICE?

IF SO, PROVIDE THE DATE AND THE FOLLOW-UP ACTION

_____

_____

PREGNANCY

WAS THE PREGNANCY MONITORED BY A PHYSICIAN? YES NO

PLEASE CHECK ALL THAT APPLY

ANEMIA	____	DESCRIBE	_____
ELEVATED BLOOD PRESSURE	____	DESCRIBE	_____
TOXEMIA	____	DESCRIBE	_____
SWOLLEN ANKLES	____	DESCRIBE	_____
KIDNEY DISEASE	____	DESCRIBE	_____
BLEEDING	____	DESCRIBE	_____
MEASLES	____	DESCRIBE	_____
GERMAN MEASLES	____	DESCRIBE	_____
FLU	____	DESCRIBE	_____
STREP THROAT	____	DESCRIBE	_____
OTHER VIRUS	____	DESCRIBE	_____
OTHER ILLNESS	____	DESCRIBE	_____
NAUSEA OR VOMITING	____	DESCRIBE	_____
INJURY	____	DESCRIBE	_____
MEDICATION(S) TAKEN	____	DESCRIBE	_____
EMOTIONAL PROBLEMS	____	DESCRIBE	_____
THREATENED MISCARRIAGE	____	DESCRIBE	_____
PREMATURE LABOR	____	DESCRIBE	_____
SEVERE EMOTIONAL DISTRESS	____	DESCRIBE	_____
SMOKING	____	DESCRIBE	_____
ALCOHOL USE	____	DESCRIBE	_____

BIRTH HISTORY

MOTHER'S AGE AT TIME OF BIRTH	_____	FATHER'S AGE AT TIME OF BIRTH	_____
LENGTH OF LABOR	_____	CHILD'S WEIGHT AT BIRTH	_____
GENERAL ANESTHESIA?	_____	SPINAL?	_____
LOCAL?	_____	WAS LABOR INDUCED?	_____
WAS LABOR PLANNED?	_____	BREECH DELIVERY?	_____
CESAREAN SECTION?	_____		

ANYTHING UNUSUAL ABOUT DELIVERY? _____

_____

ANY COMPLICATIONS? _____

_____

_____

WAS IT A MULTIPLE BIRTH (TWINS, TRIPLETS, ETC.)? IF SO, WHICH CHILD WAS BORN FIRST?

_____

_____

AT BIRTH, DID YOUR CHILD HAVE

BREATHING PROBLEMS	YES	NO	CORD AROUND NECK	YES	NO
WAS OXYGEN USED?	YES	NO	NORMAL COLOR	YES	NO

WAS YOUR CHILD PREMATURE? IF SO, BY HOW MUCH?

_____

WAS IT NECESSARY FOR YOUR CHILD TO STAY AT THE HOSPITAL LONG THAN USUAL? IF SO, HOW LONG?

_____

WERE THERE PROBLEMS WITH FEEDING? IF SO, PLEASE DESCRIBE

_____

_____

WAS YOUR CHILD NORMALLY ACTIVE AS A BABY? YES NO

DEVELOPMENTAL HISTORY

MOTOR DEVELOPMENT (SITTING, CRAWLING, WALKING)

NORMAL EARLY LATE UNSURE

SPEECH AND LANGUAGE

NORMAL EARLY LATE UNSURE

HANDEDNESS RIGHT LEFT

SELF-HELP SKILLS (DRESSING, BRUSHING, TOILETING, HYGIENE)

AVERAGE EARLY LATE UNSURE

TEMPERAMENT (INFANCY, TODDLER, PRESCHOOL) CHECK ALL THAT APPLY

SHY OR TIMID		STUBBORN		AFFECTIONATE		TEMPER OUTBURSTS	
EASY TO MANAGE		BLANK SPELLS		WANTED TO BE LEFT ALONE		FEARFUL	
CAUTIOUS		UNDERACHIEVER		OVERACTIVE		SLOW TO WARM UP	
FALLING SPELLS		IMPULSIVE		POOR SLEEP		CURIOUS	
HAPPY		POOR EATING		DESTRUCTIVE		ROCKING	
HEAD BANGING		INTO EVERYTHING		AGGRESSIVE		RECKLESS	
MORE INTERESTED IN THINGS THAN IN PEOPLE							

BOWEL TRAINED YES NO

BLADDER TRAINED YES NO

EATING BEHAVIOR PICKY EATS TOO MUCH OVEREATS SUGAR/CARBOHYDRATES

IS THE CHILD CURRENTLY EXPRESSING SUICIDAL STATEMENTS? YES NO

IF SO, PLEASE EXPLAIN

_____

_____

_____

HAS THE CHILD HAD ANY PREVIOUS SUICIDE THOUGHTS AND/OR ATTEMPTS IN THE PAST? YES NO

IF SO, PLEASE EXPLAIN

_____

_____

_____

HAS YOUR CHILD BEEN HOSPITALIZED FOR MENTAL HEALTH (LIST HOSPITAL, DATES, AND REASON)

_____

_____

_____

IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW ABOUT YOUR CHILD?

SIGNATURE

DATE

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CLIENT CONTACT PREFERENCES

PLEASE PROVIDE CONTACT METHODS BELOW AND MARK THE BOXES ACCORDING TO YOUR PREFERENCES

METHOD OF CONTACT	CHRISTIAN LIFE COUNSELING MAY LEAVE A DETAILED MESSAGE	APPOINTMENT REMINDERS
EMAIL		
CELL PHONE		
CELL PHONE		
LANDLINE		N/A

REGARDING BILLING AND SCHEDULING

PLEASE IDENTIFY INDIVIDUAL(S), OTHER THAN YOURSELF, WITH WHOM CHRISTIAN LIFE COUNSELING MAY SPEAK

NAME	NAME
NAME	NAME
NAME	NAME

I UNDERSTAND AND AGREE TO THE NATURE OF THIS RELEASE.

I WILL PROMPTLY NOTIFY CHRISTIAN LIFE COUNSELING OF ANY CHANGES TO MY INFORMATION OR PREFERENCES.

CLIENT NAME _____ CLIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ RELATIONSHIP TO CLIENT _____ DATE _____

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Fee Schedule & Late Cancellation/No-Show Policy

Psychotherapists

90791 Intake	$225.00
90847 38-52 min	$220.00
90837 53-89 min	$200.00
90834 38-52 min	$150.00
90832 16-37 min	$100.00
90853 Group 60 min	$100.00
Late Cancel Charge	$75.00

Psychologist

90791 Intake	$275.00
90847 38-52 min	$270.00
90837 53-89 min	$250.00
90834 38-52 min	$200.00
90832 16-37 min	$150.00
96101 Testing 60 min	$250.00
No-Show Charge	$100.00

Written/Standard Reports & Letters Exchanging Client Information 60 min	$200.00
Records Release to Client (per sheet)	$0.10
Required/Requested Provider Appearances (per hour, plus mileage)	$200.00

*The above charge amounts are billed to the insurance companies. If you are not using insurance, your therapist will discuss a suitable Private Pay agreement with you.

We understand there are times when you must miss an appointment due to emergencies or obligations to work or family. However, if you do not notify the office you are unable to make an appointment, you are interfering with our ability to schedule with another client. Therefore, if an appointment is not cancelled at least 24 hours in advance, you will be charged a $75.00 fee. A $100.00 fee will be charged if you fail to show for a scheduled appointment and do not call.

Late cancellation and no-show fees are not covered by insurance companies.

I will be charged:

- $75.00 if I do not cancel a scheduled appointment at least 24 hours in advance.
- $100.00 if I fail to show for a scheduled appointment and do not call.

I have read the Fee Schedule & Late Cancellation/No-Show Policy. I understand and agree to the policy.

Client	Client Signature	Date
Parent/Guardian	Parent/Guardian Signature	Date

We strongly encourage clients to leave a credit card on file for sessions. Only the last four digits will appear in the system.

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Client Acknowledgement and Authorization

- I have reviewed the *Client Rights* document available on the website (a copy will be provided upon request).
- I have reviewed the *Consent to Treatment* document available on the website (a copy will be provided upon request).
- I have reviewed the *Fee Schedule*.
- I understand if I have any questions regarding my privacy rights, I may contact:
  Tanya Gerhard at (262) 785-1008.
- I authorize you to use and disclose my personal health information to my insurance company. I also authorize the cost of treatment be made directly to Christian Life Counseling.
- I understand Christian Life Counseling and its billing company will be contacting my insurance regarding benefits/eligibility and/or claims information.
- I understand any treatment charges not covered by my insurance plan will be my responsibility.
- I understand I will be charged up to the normal fee for appointments missed without 24-hour notice. I also understand my insurance company will not pay for missed appointments.
- I understand Psychotherapy is best done in person, therefore, anticipate my therapist may suggest I meet with them if I call or email with a non-critical problem. Christian Life Counseling understands, however, some circumstances may require immediate attention. If this occurs, I can expect charges for these services, which are not often reimbursed by insurance companies. I understand email is not to be used for immediate attention or emergency care.
- I understand recording of sessions is forbidden.

It is our policy to be as responsive to clients as possible, particularly during times of crisis. Your therapist, however, will always not be available. Each therapist has a confidential voicemail upon which you may leave a message. Your therapist will check his/her voicemail at least once each day and will return your call as soon as possible.

If you have an emergency, please contact your primary physician, an emergency crisis line, or 911.

Client	Client Signature	Date
Parent/Guardian	Parent/Guardian Signature	Date