Resolve To Heal Therapeutic Associates

INTAKE FORM FOR MINORS

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

PERSONAL INFORMATION

Child's Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

PARENTAL/GUARDIAN INFORMATION

Name: _____
(Last) (First) (Middle Initial)

Occupation: _____ Age: _____

Local Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) - May we leave a message? ☐Yes ☐No

Cell/Other Phone: ( ) - May we leave a message? ☐Yes ☐No

E-mail: _____ May we email you? ☐Yes ☐No

*Please be aware that email might not be confidential.

PARENTAL/GUARDIAN INFORMATION CONT'

Name: _____
(Last) (First) (Middle Initial)

Occupation: _____ Age: _____

Local Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) - May we leave a message? ☐Yes ☐No

Cell/Other Phone: ( ) - May we leave a message? ☐Yes ☐No

E-mail: _____ May we email you? ☐Yes ☐No

EMERGENCY CONTACTS

1. _____
(Name) (Relation) (Phone Number)

2. _____
(Name) (Relation) (Phone Number)

CONSENT FOR ASSESSMENT, CONSULTATION & TREATMENT

I hereby give my consent for my child to receive an assessment, consultation and treatment.

_____ _____
(Signature) (Date)

THERE ARE TIMES WHEN RELEASE IS REQUIRED WITHOUT CONSENT – These times are when there is reasonable suspicion of child, dependent or elder abuse and when a client presents a danger to themselves or others (suicidal or homicidal ideation). Intent to destroy property may also be a cause for breaching confidentiality.

_____ _____
(Signature) (Date)

SCHOOL INFORMATION

School: _____ Phone: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Teacher: _____ Current Grade: _____

If your child has repeated any grades, which were they? _____

MAIN PROBLEMS – What are currently the main problems at school?

_____

_____

_____

_____

To authorize release of information to the school, please initial here: _____
(Initials)

MAIN PROBLEMS – What are the main problems at home?

_____

_____

MAIN PROBLEMS – What are the main problems with peers/siblings?

_____

_____

CURRENT PROVIDERS

PHYSICIAN INFORMATION

Physician: _____ Phone: _____

Address: _____

Medical Problems & Current Diagnosis: _____

Current Medication(s): _____

Past Medication(s): _____

Hospitalizations: ☐Yes ☐No If Yes, for _____

To authorize release of information to the physician, please initial here: _____

PSYCHIATRIST INFORMATION

Psychiatrist: _____ Phone: _____

Address: _____

Current Diagnosis: _____

Current Medication(s): _____

Past Medication(s): _____

Hospitalizations: ☐Yes ☐No If Yes, for _____

To authorize release of information to the psychiatrist, please initial here: _____

MEDICAL HISTORY

PRENATAL & BIRTH HISTORY

Adopted: ☐Yes ☐No If Yes, age at adoption: _____

Was pregnancy full term? ☐Yes ☐No ☐Unknown

Was there prenatal exposure to drugs/alcohol? ☐Yes ☐No ☐Unknown

Was the birth induced? ☐Yes ☐No ☐Unknown

Was the birth c-section? ☐Yes ☐No ☐Unknown

Were there any pre-natal complications? ☐Yes ☐No ☐Unknown

If yes, please explain:

_____

_____

Were they any complications during the birth? ☐Yes ☐No ☐Unknown

If yes, please explain:

_____

_____

HEALTH PROBLEMS

Directions: Please review each possible health problem and place a "✓" in the appropriate column

Headaches	☐Past ☐Present
Migraines	☐Past ☐Present
Ear Infection(s)	☐Past ☐Present
Rashes or skin problems	☐Past ☐Present
Meningitis	☐Past ☐Present
Seizures (Convulsions)	☐Past ☐Present
High Fevers (over 103)	☐Past ☐Present
Pneumonia	☐Past ☐Present
Asthma	☐Past ☐Present
Slow weight gain	☐Past ☐Present
Trouble with ears or hearing	☐Past ☐Present
Trouble with eyes or vision	☐Past ☐Present
Bowel Problems	☐Past ☐Present
Surgery (operations)	☐Past ☐Present

Head Injury/Other Injuries	☐Past ☐Present
Food allergies	☐Past ☐Present
Other Allergies	☐Past ☐Present
Anemia (low blood count)	☐Past ☐Present
Lead Poisoning	☐Past ☐Present
Other poisoning or overdose	☐Past ☐Present
Heart Problems	☐Past ☐Present

Other: _____

Reasons for Hospitalization: _____

_____

_____

_____