Marilyn Yearian, MA, LMHC

Child Intake Information

Referred by: _____

Client's Name: _____ Today's Date: _____

Address: _____

Age: ____ Birthdate: _____ Home Phone: _____ Cell Phone: _____

School: _____ Grade (K-12): _____ Grades: _____

Emergency Contact: _____ Phone: _____

Phone voice messages Yes No; Text messages Yes No _____

Insurance Information

Insured's ID Number: _____

Insured's Policy, Group, or FECA Number: _____

Insured's Name: _____ Insured's Birthdate: _____

Insured's Address: ___ Same as above or _____

Employer's Name: _____

Insurance Plan Name or Program Name: _____

Is there another health benefit plan? ___ No ___ Yes

I authorize the release of any medical or other information necessary to process this claim with my insurance company.

___ Yes ___ No Signature: _____

I authorize my insurance carrier to directly pay my practitioner.

___ Yes ___ No Signature: _____

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Child Intake Information

For divorced or separated parents, custody arrangement:

_____

_____

Mother's Name: _____ Birthdate: _____

Address: __ Same as above or _____

Phone: _____ Employer: _____

Father's Name: _____ Birthdate: _____

Address: __ Same as above or _____

Phone: _____ Employer: _____

Parents' Marital Status: Mar. Div. Sgl. Sep. Years ____ Number of previous marriages: Mom: _____ Dad: _____

Number of children: Mom & Dad: _____ Mom: _____ Dad: _____

Children and others living in household:

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Previous Psychotherapy: Yes No With whom? _____

Hospitalizations: _____

Physician's Name: _____ Phone: _____

Currently under medical care? Yes No _____

Current medications: None _____

Prenatal, early childhood: WNL _____

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Child Intake Information

Major accidents, illnesses, injuries: None _____

Trauma: None _____

Rape/Molest: None _____

Does your child have any of the following? Please circle below:

Headaches Trouble Concentrating Heart palp/Panic Tension & Anxiety Follows Directions

Depressed Lack of joy Trouble sleeping Frequent nightmares Challenges at home

Irritability Angry Outbursts Poor self image Fearful or shy School challenges

Paranoid ideas Tired/Low energy Binging/Purging OCD Sxs Appetite changes

Alcohol use: None Social _____ Binge _____

Drug use: None Present _____ Past _____

Mom: Alcohol: None Social _____ Drugs: _____

Dad: Alcohol: None Social _____ Drugs: _____

Significant family mental health and substance abuse history: _____

_____

Have you ever attempted suicide? Yes No _____

Are you currently experiencing suicidal thoughts? Yes No _____

Past or present thoughts or attempts to harm others? Yes No _____

Present or past legal problems? Yes No _____

When you are under stress or are unhappy, what do you do to feel better:

_____

Who do you turn to for support? _____

What are your strengths and interests? _____

_____

_____

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Child Intake Information

Faith: Catholic Christian JW Mormon Jewish _____ Attends: Regularly Sometimes Non-attender

_____

Why are you coming to counseling? _____

_____

_____

Who wants you to have counseling? Self Mom Dad Other _____

_____

Anything else that comes to mind that I should know: _____

_____

_____

_____

Thanks for filling out this questionnaire!

Marilyn Yearian, LMHC

Phone: (360) 789-8615 Email: mycounselingservice@gmail.com