Clack Associates, LLC
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Child/Adolescent Screening Form/Intake Assessment

Today's Date: ______________________________

Child Name: _______________________________ DOB: _______________ Age: _________

Who referred you to us? ____

Guardian Name: ____________________________ Age: ________
Guardian Name: ____________________________ Age: ________
Home Address: ____
____

List All Family Members and Others Who Are Currently Living In Your Home:

Name	Age	DOB	Relationship	Occupation

Home Phone: _______________________ Work: ________ Cell: _______________________

Parent/Guardian Employment/Primary Source of Income: _________________________________
____
Other Sources of Income: ____

Other agency involvement?____

School:_______________ Grade:________ Services:______________

Child/Adolescent Highest Level of Education/Last grade completed: _________________________
____

Briefly described your reason(s) for seeking help at this time: ______________________________
____

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____

____

How long has this been a problem?____

What other stressors are in your child's life that complicates alleviation of distress? ___________

____

____

____

What has your family already tried to cope with your current situation? ____________________

____

____

Please circle any of the following problems that pertain to your child:

Nervousness	Self Control	Fears
Shyness	Stress	Suicidal Thoughts
Separation	Headaches	Finances
Drug abuse	Memory	Friends
Anger	Insomnia	Unhappiness
Sleep	Low Self Esteem	Work
Legal Matters	School	Fatigue
Trauma	Nightmares	Body Image
Loneliness	Appetite	Making Decisions
In laws	Family	Concentration
Siblings	Health	Eating Disorder
Depression	Thoughts	
Sexual Problems	Digestion Problems	Other:
Divorce	Alcohol	

With everything that your child is going through right now has he/she thought about doing anything drastic or perhaps violent to him/herself or anyone else? _____

Has your child ever had any suicidal thoughts, feelings, or attempted suicide in the past?_______

____

Does your child have any suicidal or homicidal thoughts or feelings now? ____________________

____

Do you have any firearms, weapons, dangerous chemicals or access to these materials in your dwelling? ____________

Has your child ever received a psychological/psychiatric evaluation? YES NO

Have you or any member of your family received psychiatric and/or psychological help or counseling of any kind in the past? _________________________________

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If yes, who received treatment and the reason? ____
____
____

Who provided these services and where: ____
____
____

Was it helpful? Why or why not?____

Are you currently in treatment/counseling with another behavioral healthcare provider? _______
____

Please list any medications your child is currently prescribed?

Drug Name:________________ Dose: ______________ Started: ______Reason: ____________

Drug Name:________________ Dose: ______________ Started: ______Reason: ____________

Drug Name:________________ Dose: ______________ Started: ______Reason: ____________

Is your child currently being treated for any medical condition?____________________________
____
____

Has your child ever had an accident or fall that resulted in a concussion or head trauma (open or closed)?____
____

When did a physician last examine your child? __________________________

Name of Physician: _______________________ Phone #: ______________________________

Location: _______________________________

List any major health problems your child is currently receiving treatment for: _______________
____
____

How will you know if treatment has been successful?_____________________________________
____
____

****

Insurance Carriers	Policy Holder	Group and Policy #

Portion of Counseling Services Covered by Insurance: ____________________________

Deductible: ________________ Co Payment: ______________________________________

Insurance Carrier's Phone # for Mental Health/Substance Abuse Benefits: ___________________
____

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*Parent/Guardian: Please **initial** each of the following items to indicate your agreement:*

_______ Your insurance company/managed health care group might **require** that clinical information be provided to them in order for you to receive these services. If your carrier denies payment or pre-certification of benefits, you will be responsible for payment.

_______ All fees are payable at the time of visit(s), unless special arrangements have been made. Your insurance/mental health group might require pre-authorization for your treatment visits. The group might require pre-authorization for your treatment visits.

_______ Appointments cancelled without adequate notification (24 hours notice) or broken without justifiable reason will be billed at the missed session rate. This fee is not reimbursable by your policy coverage.

_____________________ ____

Date Your Full Signature

Client Name:

Child/Adolescent Assessment Intake Form CA02