APPLICATION FOR SERVICES

Date: ____________

Name:_______________________________ Date of Birth: __________________________

Client's Name: ________________________

Primary Language: ____________________ Sex: M:____F:____T: ____

Home Phone:_________________School:_____________________Grade:_____________________

Please list emergency contact: ____

Relationship:___________________Age:________Occupation:______________________________

Address:____

Phone:________________________Email:____

Preferred method of contact:___________Able to leave message: ___________________________

Parent/Guardian #1 Name (if different from above): ____

Relationship to client: ____

Marital Status:___________________Age:________Occupation: ____________________________

Is address the same as the client?:_______If no, enter the address below:

Phone:____

Married:______Divorced:_____Widowed: _____

Parent/Guardian #2 Name (if different from above): ____

Relationship to client: ____

Marital Status:___________________Age:________Occupation:_____________________________

Is address the same as the client?:_______If no, enter the address below:

Phone:____

Married:______Divorced:_____Widowed: _____

APPLICATION FOR SERVICES (Continued)

Please list other immediate family members:

Name:____

Relationship to client: ____

Marital Status:__________________Age:________Occupation:

Address:____

Phone: ____

REFERRAL INFORMATION

Reason for Referral (What is the main issue for which you are seeking help at this time?):

How often does this issue or behavior occur? (5x/day, 2x/week, etc.):

How long has this been happening?:

How is this affecting you at home? In school? In peer relationships?:

Has the person been seen previously for psychological or psychiatric consultation?:________If yes, name of professional:

Dates of service: ____

Was an evaluation completed?: ____

What type of evaluation?:____

If there has been a past evaluation, please bring a copy of the evaluation to the first visit. We will have you complete a consent form in the office to allow us to communicate with your prior professional.

How were you referred to this practice?:

MEDICAL INFORMATION

Please describe client's present state of health?:

Please list client's medical issues:

Please list any current medications:

Please list client's PCP and practice:

Please list history of surgeries or serious illnesses:

Please list allergies:

Please list caffeine, tobacco, alcohol or other drug use:

MEDICAL EVALUATION REQUIREMENT

A.

I have had a physical exam within the past 6 months and authorize my physician to release a summary of findings and medical status to Rita Vatcher, LMHC (see attached release).

B.

I have not had a physical examination in the past 6 months, but will seek one out within the next month and release a summary of findings and medical status to Rita Vatcher, LMHC.

If you do not have a primary care physician, we will give you the names of three health care providers whom you may contact. (Client to bring release of information to his/her physician at time of exam) Signature:________________________________Date:___________________

C.

I have not had and refuse to seek, or refuse to release the results of a physical examination to Rita Vatcher, LMHC.

Reason for refusal:

Signature:____Date: ___________________

FAMILY HISTORY

Please indicate if any of the following issues are currently being experienced within the immediate family (parents, siblings):

______Marital difficulties
______Divorce/separation of parents
______Serious illness of parent, child, sibling
______Birth of new child
______Job loss
_____Death in family
_____Recent move
_____Financial problems
_____Single parent
_____Other___________________

If yes to "serious illness of parent, child, sibling" please specify:

Please indicate which of the following concerns have been experience in the immediate and/or extended family (parents, siblings, aunts, uncles, cousins, grandparents):

______Autism Spectrum Disorders
______Learning Disabilities
______Mental Retardation
______Birth Defects
______Depression
______Anxiety
______Phobias
______High Blood Pressure
______Cancer
_____Diabetes
_____Attention Deficit Hyperactivity Disorder (ADHD)
_____Alcoholism
_____Drug Addiction
_____Bipolar Disorder
_____Suicide (threats/attempts/completed)
_____Psychiatric Hospitalizations
_____High Cholesterol
_____Heart Disease

If yes to any of the above, specify the relationship to the client:

BACKGROUND INFORMATION

EARLY CHILDHOOD

Please indicate when your child demonstrated each developmental milestone:

Child Walked

- ☐ <12 months
- ☐ 12-24 months
- ☐ 24-36 months
- ☐ >36 months
- ☐ Has never Walked

Child Spoke Words

- ☐ <12 months
- ☐ 12-24 months
- ☐ 24-36 months
- ☐ >36 months
- ☐ Has never Spoke Words

Child Spoke Sentences

- ☐ <12 months
- ☐ 12-24 months
- ☐ 24-36 months
- ☐ >36 months
- ☐ Has never Spoke Sentences

Child First Trained for Urination

- ☐ <12 months
- ☐ 12-24 months
- ☐ 24-36 months
- ☐ >36 months
- ☐ Not Trained Yet

Child First Trained for Bowels

- ☐ <12 months
- ☐ 12-24 months
- ☐ 24-36 months
- ☐ >36 months
- ☐ Not Trained Yet

Since Initial Toilet Training

☐ Frequent wetting during the day
☐ Frequent wetting during the night
☐ Frequent soiling during the day
☐ Frequent soiling during the night
☐ Not Trained Yet

PUBERTY

Onset of puberty*

☐ <10 years
☐ 10-12 years
☐ 12-14 years
☐ 14-16 years
☐ >16 years
☐ Not Yet Developed

***(breast development, menstruation, pubic hair, facial hair)**

EDUCATIONAL

If you have any educational concerns, please bring copies of report cards to visit.

List all schools your child has attended, beginning with the most recent:

Has your child ever repeated a grade:_____If yes, what was the reason?: ___________________

Has your child ever had problems in school?:_______If so, describe: ________________________

Please indicate where your child is performing academically:

	Below Grade Level	On Grade Level	Above Grade Level
Language Arts			
Mathematics			
Writing			

Does your child enjoy attending school:______If no, please explain: ________________________

Has your child ever been referred for educational interventions, such as additional academic assistance, behavioral management plans, etc.?:

If yes, please describe: ____

Is your child currently on a 504 plan?: ____

If yes, what is your child’s diagnosis and the 504 Plan intervention: ________________________

Is your child currently in Special Education?: ____

Date of most recent IEP: ____

Educational Disability:____

Services Receiving: ____

Do you feel the interventions (informal/504/Special Education) are effective?: ________________

If no, please explain: ____

____

FAMILY/HOME ENVIRONMENT

Please list all those living in the child’s home (relationship, date of birth, occupation/school grade):

Please list other persons closely involved with the child but not living in the child’s home (i.e. older siblings, grandparents, sitters, teachers, etc.) Please list frequency of visits.:

If child is not living with both biological parents, is either parent deceased?:______If so, please specify:

Were biological parents married?:

Are biological parents divorced/separated?:_______If so, when?:

Which parent has custody?:

How often does non-custodial parent visit?:

How long have your lived at the current address?:

How often have you changed residences since the birth of the child?: ____

Does the child share a bedroom?:______If so, with whom?:

Does your child have difficulty with siblings?:______If yes, please explain:

Was the child ever placed or boarded away from the family?:______If yes, indicate reason for placement, where, and with whom?: ____

Has your child ever had difficulty or contact with legal authorities (Police, Juvenile Justice)?: _____If yes, please describe circumstances?:

Please describe any religious or cultural beliefs you would like incorporated into your child's treatment: ____

ACADEMIC/BEHAVIORAL CHECKLIST

Please indicate if your child is currently exhibiting difficulty with any of the following:

Reading – Basic Skills

- ☐ Difficulty recognizing letters
- ☐ Difficulty reciting the alphabet
- ☐ Difficulty reading aloud (loses place or skips words)
- ☐ Dislikes reading/reluctant to read
- ☐ Reads slowly
- ☐ Not Applicable

Reading – Comprehension

- ☐ Difficulty understanding the meaning of words
- ☐ Difficulty understanding the meaning of passages
- ☐ Difficulty identifying main idea
- ☐ Difficulty drawing conclusions
- ☐ Difficulty following written directions
- ☐ Difficulty understanding idioms or figurative language
- ☐ Not Applicable

Math Calculation

- ☐ Difficulty identifying numerals
- ☐ Difficulty counting by rote
- ☐ Difficulty understanding basic arithmetic facts
- ☐ Difficulty completing problems involving basic calculation
- ☐ Difficulty completing problems involving fractions or decimals
- ☐ Difficulty completing problems involving geometric shapes
- ☐ Difficulty completing problems with more than one step
- ☐ Not Applicable

Math Reasoning

- ☐ Difficulty understanding concepts related to size, sequence or quantity
- ☐ Difficulty identifying and using appropriate problem-solving strategies
- ☐ Difficulty solving word problems
- ☐ Difficulty completing problems involving estimation or prediction
- ☐ Difficulty understanding charts, tables, and graphs
- ☐ Difficulty generalizing math skills to other types of problems or tasks
- ☐ Difficulty understanding abstract mathematical concepts
- ☐ Not Applicable

Written Expression

- ☐ Difficulty writing information dictated by others
- ☐ Difficulty with basic mechanics of writing
- ☐ Confused the order of words in sentences
- ☐ Writes in incomplete sentences
- ☐ Uses simplistic language when writing
- ☐ Difficulty expressing ideas in writing
- ☐ Dislikes/avoids written tasks
- ☐ Poor handwriting (difficulty with letter formation, poor spacing between letters and words)
- ☐ Difficulty copying from blackboard
- ☐ Not Applicable

Oral Expression

- ☐ Confuses or leaves out speech sounds
- ☐ Disfluency (unusual pauses or repetitions, frequent rephrasing, poor verbal organization)
- ☐ Grammatical problems (incorrect use of plurals, verb tense forms, pronouns, etc.)
- ☐ Limited vocabulary
- ☐ Word retrieval problems
- ☐ Problems with social language (initiating conversations, expressing thoughts and feelings, asking questions, etc.)
- ☐ Does not speak in class to teachers/students
- ☐ Not Applicable

Listening Comprehension

- ☐ Difficulty following oral directions
- ☐ Frequently asks or repetition of oral instructions
- ☐ Misunderstands spoken word
- ☐ Easily distracted by noises or other sounds
- ☐ Exhibits short attention span during auditory tasks
- ☐ Confuses similar words
- ☐ Difficulty understanding sentences that are long or complex
- ☐ Cannot repeat information that was just spoken
- ☐ Appears disinterested in audio information (tapes, recordings, etc.)
- ☐ Demonstrates disruptive or off-task behaviors when required to listen
- ☐ Not Applicable

Social Behaviors

- ☐ Difficulty responding to questions within expected time limits
- ☐ Misinterprets facial expressions or body language
- ☐ Overreacts to perceived insults
- ☐ Does not understand teasing, sarcasm, jokes
- ☐ Has few or no friends
- ☐ Displays attention-getting behaviors, acts like “class clown”
- ☐ Misinterprets tone of voice
- ☐ Isolated from others – few group or social interactions
- ☐ Withdrawn – does not make eye contact, seems introverted, does not participate in discussions
- ☐ Not Applicable

Other Behaviors

- ☐ Excessively out of seat
- ☐ Refuses to comply with requests
- ☐ Withdrawn
- ☐ Interrupts others when speaking
- ☐ Uses foul language
- ☐ Frequently fights with peers
- ☐ Engages in risky behaviors
- ☐ Associates with children that have been in trouble
- ☐ Difficulty focusing
- ☐ Poorly organized
- ☐ Experiences difficulty starting tasks
- ☐ Acts before thinking
- ☐ Can’t sit still
- ☐ Experiences difficulty planning
- ☐ Not Applicable

Comments:

HEALTH INSURANCE

I certify that I, and/or my dependent(s) have insurance coverage with ______________________________(name of insurance) and assign directly to Rita Vatcher, LMHC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Rita Vatcher, LMHC may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I understand that if I have a co-payment with my insurance plan, payment is expected at the time of service by check, cash, or credit card (Visa or MasterCard). **If my insurance plan does not cover a session, I am responsible for payment of these charges at a rate of $140 per contact hour.** Please note, verification of benefits does not guarantee payment of a claim in full. If Rita Vatcher, LMHC is an out-of-network provider in my plan, I am responsible for payment at the time of service and it is my responsibility to submit paperwork to my insurance provider for reimbursement directly to me. This consent will end one year from the date signed below.

Client/Parent/Legal Guardian Signature_________________________ Date: ______________

If applicable, please provide the following insurance information:

Name of the Insurance Subscriber: ____

Subscriber's DOB: ____

Subscriber ID #: ____

Subscriber Group #: ____

Ins. Phone # for Mental Health Benefits: ____

Ins. Phone # for Medical Health Benefits: ____

Name of employer or other entity where health plan is obtained:___________________________

Is your health insurance plan either: a union plan, employer self-funded plan, or a trust plan?: ____________________________________If yes, please provide plan contact name and phone #:

CANCELLATION POLICY

24-hour notice is required for cancellation, except in the case of sudden illness. Otherwise, missed appointments must be paid in full.

Client/Parent/Legal Guardian Signature______________ Date: ______________

PERMISSION TO TREAT A MINOR:

As legal guardian for___________, I hereby give permission for this minor to receive counseling services from Rita Vatcher, LMHC.

Permission to treat does not dismiss the rights of the minor from protection under the Federal Confidentiality guidelines. Any release of information form must contain the signature of both the minor and the guardian in order to be valid.

Signature:____________________________Clinician: _________________________

Date: __________________