DELMORE COUNSELING, LLC

One Crosswoods Bldg · 100 East Campus View Blvd., Suite 155 · Columbus, Ohio 43235

Client Name: ______________________________

Street Address: ______________________________ City/State/Zip: ______________________________

Home Phone #: ______________________ Can we call or leave a message at this number? ❑Yes ❑No

Daytime Phone #: ______________________ Can we contact you here? ❑Yes ❑No

Cell Phone #: ______________________ Can we call or leave a message on this phone? ❑Yes ❑No

Email Addresses: ______________________________

Client Date of Birth: __________________ Age: _____ Social Security #: ______________________

Parent/Responsible Party Name (if client is minor): ______________________________

Primary Care Physician: ______________________________

Emergency Contact Name: ______________________________ **Phone #:** ______________________

Referral Source: ______________________________

** Self-Pay or Insurance Information (Provide Copy of Insurance Card) **

For Self-Pay Option, Please Identify Responsible Party Name: ______________________________

Primary Insurance Company: ______________________________ Ins. Co Phone #: ______________________

Employer of Subscriber: ______________________________

Name of Subscriber: ______________________________ Date of Birth: ______________________

Address of Subscriber (if different from Client): ______________________________

Subscribers Social Security #: ______________________________ Relationship to Client: ______________________

****FOR OFFICE USE ONLY****

____Out of Network ____In Network

Phone: ______________________________ Spoke to: ______________________________

Effective Date: ______________________________ Calendar or Benefit Year: ______________________

Deductible: ______________________________ % Insurance Pays: ______________________

Claims Address: ______________________________ Yearly Max: ______________________

____

____

****If Pre-cert is required****

Phone: ______________________________ Start Date: ______________________________

Authorization #: ______________________________ Number of Sessions: ______________________

CLIENT AGREEMENT:

The above information is current and correct to the best of my knowledge. I understand my insurance coverage as noted above and that I am responsible for paying the co-pay, if required, and/or the amount not covered by my insurance policy. This agreement also grants authorization to Delmore Counseling, LLC to release such information as may be necessary for completion of my insurance claim with payment of benefits to Delmore Counseling, LLC for services rendered.

______________________________ ______________________________ ______________________________

Client Name (please print) Client Signature Date

______________________________ ______________________________ ______________________________

Parent/Guardian Name (if client is minor) Parent/Guardian Signature Date

______________________________ ______________________________

Witness Date

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Child/Adolescent Client Intake Form

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to the child, leave them blank.

Information supplied by: ___________________________ Relationship: ______________ Today's Date: ______________

Identifying Information
Child's Name:_________________________________ **Date of Birth:** ________________ **Age:**________ **Gender:** ❑ Male ❑Female **Race:** _____________ **Height:** ______________ **Weight:**____________ **Hair Color:**______________ **Eye Color:** _______________

Behavioral Health		
Why is the child coming to counseling?		
What issues or circumstances do you believe contribute to the child's problems?		
How long has this problem persisted? ___________		
Under what conditions do the problems usually get worse?		
Under what conditions do the problems usually improve?		
Has the child previously been involved in counseling? ❑No ❑ Yes **If yes, describe the reasons for counseling and who provided the counseling.** **Counselor:** **Reason:** **Outcome:**		
List your child's greatest strengths:		
List your child's greatest weaknesses:		
List your child's main difficulties at home:		
List your child's main difficulties at school:		
Psychiatric Hospitalizations: ❑None ❑Past ❑Current		
Dates of Service:	**# of Days**	**Where & Reason (suicidal, depressed etc.)**

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Behavioral Health Symptom Checklist

Please indicate the degree to which you have experienced any of the following symptoms in the last 4 weeks.

0 = Never 1 = Occasionally 2 = Regularly 3 = Frequently

_______1. Trembling, or feeling shaky
_______2. Shortness of breath or smothering sensation
_______3. Racing heart, heart palpitations or chest pain (circle which)
_______4. Moist palms or excessive sweating
_______5. Dizziness, lightheadedness, unsteady or faint (circle which)
_______6. Nausea, diarrhea, or other abdominal distress (circle which)
_______7. Frequent headaches or other muscle aches
_______8. Startle easily
_______9. Irritability (loses temper easily)
_______10. Worrying a lot
_______11. Trouble swallowing, “lump in throat”, or choking sensation
_______12. Fearful of or embarrassed by being watched or being the focus of attention
_______13. Avoid talking to strangers
_______14. Fear of embarrassment
_______15. Persistent fear of an object (snakes) or situation (high places) considered excessive or unreasonable
_______16. High levels of anxiety in the presence of an object or situation
_______17. Regular and disturbing thoughts about a past traumatic experience
_______18. Regular and disturbing dreams about a past traumatic experience
_______19. Avoidance of thoughts feelings, or conversations associated with a traumatic experience
_______20. Excessive hand washing or fear of germs
_______21. Excessive checking (i.e., doors, locks, stove)
_______22. Excessive need for order or neatness or counting ritual(s)
_______23. Unusual and persistent sad feelings
_______24. Diminished interest or participation in enjoyable or important activities
_______25. Difficulty concentrating or poor memory (circle which)
_______26. Tire easily or low energy level
_______27. Thoughts of suicide
_______28. Increased or decreased sleep (circle which): avg. hrs per night ____
_______29. Feelings of hopelessness
_______30. Persistent and abnormally elevated mood
_______31. Over inflated feelings of self-worth
_______32. Decreased need for sleep
_______33. Rapid or racing thoughts
_______34. Excessive involvement in pleasurable activities
_______35. Excessive and/or reckless spending
_______36. See or hear things that others around you are unable to perceive
_______37. Hold ideas or beliefs that are not shared by others
_______38. Self induced vomiting
_______39. Excessive exercise
_______40. Use of laxatives or diuretics to lose weight
_______41. Dieting (very strict, women consuming less than 1400 daily calories or men less than 2000 calories)
_______42. Careless mistakes in school work, work, or other activities
_______43. Can only pay attention for short periods at school/work/home
_______44. Failure to complete schoolwork, chores, duties
_______45. Hyperactive: fidgets, squirms, talks excessively
_______46. Acts without thinking of consequences

Drug and Alcohol History

Indicate the level of use for each substance by checking the appropriate box.

	No Use	Past use	Current Use		No Use	Past use	Current Use
Alcohol	❑	❑	❑	**Hallucinogens**	❑	❑	❑
Marijuana	❑	❑	❑	**Inhalants**	❑	❑	❑
Hashish	❑	❑	❑	**Cocaine**	❑	❑	❑
Stimulants	❑	❑	❑	**Heroin**	❑	❑	❑
Sedatives	❑	❑	❑	**Other**: ______________	❑	❑	❑

If current or past use is indicated to any of the above items complete the following questions?

Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method ❑Oral ❑Smoked ❑Nasal ❑Injection
Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method ❑Oral ❑Smoked ❑Nasal ❑Injection
Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method ❑Oral ❑Smoked ❑Nasal ❑Injection

Has the child ever received inpatient drug and/or alcohol treatment? ❑ No ❑ Yes

If yes, When? ________________________ **Where?** ____________________________

Has the child ever received outpatient drug and/or alcohol treatment? ❑ No ❑ Yes

If yes, When? ________________________ **Where?** ____________________________

Is the child currently pregnant? ❑ No ❑ Yes **Is the child an IV drug user?** ❑ No ❑ Yes

Family History

Parent's marital status: ❑ Married ❑ Divorced ❑ Separated ❑ Never Married ❑ Widowed

If the parents are not married, the child's age when divorce, separation or parents death occurred? __________

What is the relationship between the child and his/her custodial parent(s) Check all that apply:

❑Parents married, together ❑Single Parent Mother ❑Single Parent Father ❑ Parents Unmarried
❑Mother & Stepfather ❑Father & Stepmother ❑Adoptive Family
❑Other ________________________

Living Situation: ❑ Parent's Home ❑Foster Home ❑ Relative's Home ❑Homeless ❑Group Home
❑Residential ❑ Other ____

Household members Names (if client lives in more than one household list household 1 – 2)	Relation to the Client	Age	Race	Occupation or School	Level of Education

Significant Family Members/Others not listed above:	Relation to the Client	Age	Race	Occupation or School	Level of Education

Mother's age: _______ **If deceased, how old was the child when she passed away?** _________

Father's age: _______ **If deceased, how old was the child when he passed away?** ________

Number of Brothers ______ **Their ages:** _____ _____ _____ _____ ______

Number of Sisters ______ **Their ages:** _____ _____ _____ _____ ______

Where is the child in birth order (i.e. 1st born, 2nd born etc.) of his/her siblings? ________________

Briefly describe the child's relationship with his/her siblings:

Briefly describe the style of parenting, including types of discipline, used in the household:

Briefly describe when discipline is typically used in your household:

Parent's Employment Information:

Mother's Current Employment Status ❑Employed ❑Unemployed Job/Occupation:__________________________

Name of employer: ___________________ Date Last Worked_________________ Satisfied with Job ❑Yes ❑No

Father's Current Employment Status ❑Employed ❑Unemployed Job/Occupation:__________________________

Name of employer: ___________________ Date Last Worked_________________ Satisfied with Job ❑Yes ❑No

Developmental History

List any drugs/medications used by the mother or family at the time of conception or by the mother during pregnancy:

Indicate important physical development issues including developmental milestones including sensory, motor, cognitive, mental retardation or autism:

List the ages when the following developmental milestones occurred:

	Age	Comments
Walking	_____	____
Talking	_____	____
Toilet Trained	_____	____

Rate your child's development, compared to others the same age in the following areas

Social Development	❑Below Average	❑Average	❑Above Average
Physical Development	❑Below Average	❑Average	❑Above Average
Language	❑Below Average	❑Average	❑Above Average
Intellectual Ability	❑Below Average	❑Average	❑Above Average
Emotional Expression	❑Below Average	❑Average	❑Above Average

For each type of development that you rated as *Below Average*, describe your current *specific* areas of concern:

____
____
____
____
____

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Medical History

Physician Name: ____

Address: ____

Street & Number **City** **State** **Zip**

Date of most recent physical exam: ________________ **By Whom:** ____________________ **Phone:** ________________

Results: ____

Immunizations Check the immunizations for the following diseases:

❑ Chicken Pox ❑Diphtheria ❑ German Measles ❑Measles ❑Mumps
❑Polio ❑ Small Pox ❑Tetanus

Allergies:

List any major illnesses and/or operations:

Has the child had any medical hospitalizations in the last three years? ❑ No ❑ Yes, If yes, complete below:

Hospital	City	Date	Reason

List any *current* physical concerns (e.g. high blood pressure, headaches, dizziness, etc.):

List any *past* physical concerns:

Has the child ever had head trauma that resulted in loss of consciousness and/or required medical treatment? ❑ No ❑ Yes

What medications are they currently taking? *List all medications including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.*

Prescription/Over the Counter Medication: ❑No ❑ Yes	**Out of Medication:** ❑ No ❑ Yes
Current Medication: ________ **Total Daily Dosage:** ________ **Reason:** ________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** ________ **Total Daily Dosage:** ________ **Reason:** ________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown
Current Medication: ________ **Total Daily Dosage:** ________ **Reason:** ________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** ________ **Total Daily Dosage:** ________ **Reason:** ________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown
Current Medication: ________ **Total Daily Dosage:** ________ **Reason:** ________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** ________ **Total Daily Dosage:** ________ **Reason:** ________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown

Does the client/family think medications help the client feel better? N/A No Yes Unknown

Please list PAST medication usage (Dosage, Approximate Dates of Compliance, Reason for Discontinuing):

____
____
____
____
____

Does your child use caffeine? ❑ No ❑ Yes from (coffee, tea, soda)____________________ Daily Use____________
Does your child use tobacco? ❑ No ❑ Yes from (cigarettes, snuff) ____________________ Daily Use____________

On the average, how many hours of sleep does your child receive nightly? ______________

After going to bed, how long does it take your child to fall asleep? ______________

If falling asleep is a problem, how long has it been a problem? ______________

Does your child regularly awaken in the night? ❑ No ❑Yes

Does your child regularly have bad dreams or nightmares? ❑ No ❑Yes

Does your child experience bad dreams and is unable to awaken during them? ❑ No ❑Yes

Describe your child's appetite? ❑ Poor Appetite ❑Average Appetite ❑Large Appetite
Has the child's weight changed in the last year? ❑ No ❑ Yes If yes, by how much? __________ ❑ weight gain ❑loss

Has client had any of the following <u>symptoms in the past 60 days</u>? ***Please check*.**

❑ Bedwetting
❑ Blood in Stool
❑ Breathing Difficulty
❑ Confusion
❑Consciousness Loss
❑Constipation
❑Coughing
❑Diarrhea
❑Dizziness
❑Falling
❑Gait Unsteadiness
❑Hearing Loss
❑Lightheadedness
❑Memory Problems
❑Muscle Weakness
❑Nervousness
❑Panic Attacks
❑Pulse Irregularity
❑Sleep Problems
❑Seizures
❑Tingling in Arms/Leg
❑Tremors
❑ Vision Changes
❑ Vomiting
❑ Other: ____

Health History Questionnaire

Has the client **<u>or any of the relatives (related by blood)</u>** had any of the following health problems? If a blood relative has had the condition, please write down the relationship to the client (parent, brother, sister, aunt/uncle, cousin, children, etc.) in the comment section below.

	Client			Family History	Relationship to the Client
Problem	**Now**	**Past**	**Never**		
AIDS/HIV					
Alcoholism					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Brain Tumor					
Cancer					
Cirrhosis					
Depression					
Diabetes					
Drug Abuse					
Eating Disorder					
Epilepsy/Seizures					
Eye Disease					
GI Problems					
Glaucoma					

Headaches					
Head Injury					
Hearing Problems					
Heart Disease					
Hepatitis					
High Blood Pressure					
Hyperactivity					
Jaundice					
Kidney Disease					
Learning Problems					
Lung Disease					
Low Blood Pressure					
Menstrual Pain					
Obsessive Compulsive Disorder					
Oral Health/Dental					
Schizophrenia					
Sexually Transmitted Disease					
Speech Problems					
Stroke					
Suicide					
Thyroid					
Tuberculosis					

If the client has had any of the above , please write the problem, what treatment was received, and when in the spaces below:

Problem & Treatment received:	**When**
Problem & Treatment received:	**When**

Educational History

School: ______________________________________
Highest Academic Year completed:_____ **Highest Vocational Year Completed: (if applicable)**______

Type of school placement: ❑ Regular ❑ Special Education ❑Home-Schooled ❑Unknown

Type of Special Education Placement: ❑ None ❑Cognitive Disability ❑Emotional Disability ❑Learning Disability ❑Multiple Disabilities ❑Other: ____

Does your child experience any of the following problems (check all that apply)**:**
❑ Poor Attendance ❑Poor Grades ❑Suspension/Expulsion

Has your child ever been retained in a grade? ❑ No ❑ Yes **If yes, which grade(s):** ________________________________

Has your child passed the school's proficiency tests? ❑Yes ❑No ❑ Does not apply

Does your child have special communication needs? ❑ TTD Device ❑Interpreter Services

Has your child ever been tested for psychological/psychiatric issues? ❑ No ❑ Yes
If yes, please describe: ____

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Legal History and Children Services Involvement	
Legal Guardian(s)/Custodians:	**Phone Numbers of Guardian(s)/Custodians:**
Current Legal Status ❑None ❑On Probation ❑Detention ❑On Parole ❑Awaiting Charges ❑Other ______________________________	
Convictions:	
Incarcerations:	
Probation/Parole Officer (if applicable):	**Phone:**
Juvenile Court Involvement (for Child Abuse, Neglect or Dependency) **Current** ❑No ❑Yes **Past** ❑No ❑Yes	
Family Court Ordered into Counseling ❑No ❑Yes	
Juvenile Court Case worker (if applicable):	**Phone:**
Civil Court Proceedings:	
Domestic Relations Court Involvement (i.e. Custody, Protective Services, Restraining Order):	
Child Support Enforcement Orders:	
Children's Protective Services Involvement with Family: ❑No ❑Yes	
Name of GAL/CASA assigned to family (if applicable):	**Phone:**
Name of Children Services Caseworker assigned to the family (if applicable):	**Phone:**

To the best of my knowledge, all the information I have given is accurate. I understand the information contained in my chart that is maintained at Delmore Counseling, LLC, may not be released to anyone without my written consent, with these exceptions:

- If the law mandates disclosure
- If you have placed yourself or someone else in clear and imminent danger
- For the purposes of therapist supervision and/or consultation that falls within the ethical guidelines of the Social Work, Counseling, and Psychiatry Boards.

CLIENT'S SIGNATURE ______________________________ **DATE** ____________________

PARENT OR LEGAL GUARDIAN SIGNATURE______________________________ **DATE**____________________

PLEASE PRINT LAST NAME ______________________________ **FIRST NAME** ____________________