

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): _____

Emergency Contact Name: _____ Phone #: _____

Referral Source: _____

Services rendered by Dr. Janice L. Craig MD will be on a fee for service basis. You can submit these sessions to your insurance for reimbursement but Delmore Counseling, LLC will not be responsible for doing so. Our billing department can provide you with a billing code, diagnosis, and date of service form that will assist you with that process if you chose to submit to insurance. Dr. Craig's services are to be paid in full each session.

Dr. Janice L. Craig's fee schedule is as follows:

- **Initial Evaluation Session - \$300.00 per hour. Initial evaluations can last anywhere from 1 – 1.5 hours in duration.**
- **1 Hour Medication Management Session - \$300.00**
- **½ Hour Medication Management Session - \$150.00**

CLIENT AGREEMENT:

The above information is current and correct to the best of my knowledge. I understand that Dr. Craig's session will be required to be paid in full at time of service. Delmore Counseling, LLC accepts most major credit cards, cash, or checks as form of payment.

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 for an evaluation for medication?

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

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method
					<input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
					<input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
					<input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> 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:

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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:

	<u>Age</u>	<u>Comments</u>
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

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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: _____

Legal History and Children Services Involvement

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Legal Guardian(s)/Custodians:	Phone Numbers of Guardian(s)/Custodians:
Current Legal Status <input type="checkbox"/> None <input type="checkbox"/> On Probation <input type="checkbox"/> Detention <input type="checkbox"/> On Parole <input type="checkbox"/> Awaiting Charges <input type="checkbox"/> Other _____	
Convictions:	
Incarcerations:	
Probation/Parole Officer (if applicable):	Phone:
Juvenile Court Involvement (for Child Abuse, Neglect or Dependency) Current <input type="checkbox"/> No <input type="checkbox"/> Yes Past <input type="checkbox"/> No <input type="checkbox"/> Yes	
Family Court Ordered into Counseling <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> 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** _____