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# ADOLESCENT INTAKE INFORMATION FORM

Name of Patient: ______________________________________________DOB:________ Sex: _______

Name of Individual Completing this Form: _________________________________________________

Mother's Name: ______________________________Father's Name:_____________________________

Patient's Address: ____________________________________________________ Zip ______________

Patient Lives with Mother:_________Father:__________Both:__________ Other (Name):___________

Home Phone: ___________________Mother's Preferred Contact Phone:_________________________

Father's Preferred Contact Phone: ___________________Patient's Contact Phone:_________________

Primary purpose of your visit to this office: _________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

## I. REFERRAL INFORMATION:

Who suggested you consult me? ____________________________________________________________

Ever received services from other mental health professional(s) (who, what & when)? ______________
______________________________________________________________________________________
______________________________________________________________________________________

**II. PAYMENT INFORMATION**: Payment of my fee is expected at the time of your appointment unless you have made another arrangement with me. If you would like to file claims for reimbursement by your insurance provider, let me know if you would like my office to provide you with a monthly statement to be utilized for this process. If you would like my office to file insurance claims for you, please attach a copy of the front and back of the patient's insurance card.

## III. MEDICAL HISTORY:

Current/Past Medical Problems: ____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Current Medications: ____________________________________________________________________

## IV. PERSONAL & FAMILY HISTORY:

Marital status of patient's parents (check all that apply):

Married______; Unmarried______; Divorced______(# of times)

If patient has siblings, number of siblings ___ ; Biological ___ Adopted___Step___

Name __________________________ Sex ___ Age ___ Lives in patient's household? ___

Name __________________________ Sex ___ Age ___ Lives in patient's household? ___

Name __________________________ Sex ___ Age ___ Lives in patient's household? ___

Has the PATIENT experienced any of the following? (Check all that apply):

___ Depression ___Suicidal ___ Drug Abuse ___Alcohol Abuse ___Seizures
___Anxiety, Phobia or Panic Attack ___Schizophrenia or Psychosis
___Manic Depression, Bipolar Disorder, or Mood Swings ___ Attention Problems
___Developmental Delay or Mental Retardation ___ Learning Problems ___ Sexual Abuse
___Physical Abuse, Domestic Violence ___ Major Accidents/Injuries ___Neglect
___Psychiatric Hospitalization ___Legal Problems/Incarceration

| Patient's Mother | Patient's Father |
| --- | --- |
| Occupation: __________________________ | Occupation: __________________________ |
| Education: ___________________________ | Education: ___________________________ |
| General Health: _______________________ | General Health: _______________________ |
| Serious illness: ________________________ | Serious illness: ________________________ |
| If living, current age: ___________________ | If living, current age: ___________________ |

Is there a FAMILY HISTORY of (indicate “M” for Mother’s side and “F” for Father’s side)

___ Depression ___Suicidal ___Drug Abuse ___Alcohol Abuse ___Seizures
___Anxiety, Phobia, or Panic Attack ___ Schizophrenia or Psychosis
___Manic Depression, Bipolar Disorder, or Mood Swings ___Attention Problems
___Developmental Delay or Mental Retardation ___Learning Problems ___Sexual Abuse
___Physical Abuse, Domestic Violence ___Neglect ___Psychiatric Hospitalization
___Legal Problems/Incarceration

**V. UNDERSTAINDING OF CONFIDENTIALITY:**

I understand that the information that I/we provide to Dr. Scalf-McIver will remain confidential unless a parent of the minor patient provides written or verbal consent for her to release that information. However, confidentiality will not be kept by Dr. Scalf-McIver in the following circumstances: 1) If she judges that there is a threat to the physical safety of the patient or others (e.g. patient threatening to kill or hurt self or others); 2) If she becomes aware that a child or elder is possibly being physically or sexually abused or neglected; or 3) If I/we/patient engage in a legal action in which I/we/patient hold out my/our/patient’s emotional or mental status as an issue.

_______________________________________________ ________________________________
Signature of Parent Date

**VI: FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT:**

I authorize treatment or evaluation of the patient named and agree to take responsibility for all fees and charges for such treatment. Although my insurance may reimburse Dr. Scalf-McIver or me for many of these charges, I understand that I am responsible for full payment at the time they are rendered unless other arrangements have been made with Dr. Scalf-McIver.

Appointments with Dr. Scalf-McIver may be cancelled with 72 hours (3 business days) or more advance notice without any service charge to my account. However, if I cancel my appointment **less than 72 hours (3 business days) prior to the scheduled time, the full fee for the session will be charged.** If I do not show up for a session, the full fee will be charged.

_______________________________________________ ________________________________
Signature of Responsible Party Date

**VII. INSURANCE RELEASE:**

I hereby authorize the release of information necessary to process the patient’s insurance claims. It is understood that such information is confidential and solely for the purpose of insurance claims. This authorization will remain in effect until rescinded in writing. A photocopy will be as valid as the original.

_______________________________________________ ________________________________
Signature of Responsible Party Date

## VIII. COMMUNICATION:

Although we live in an age in which texting, instant messaging, and emailing are commonly used, I do not use any of these devices for communication as a part of my mental health practice. I do not respond to any of these forms of communication. I WILL respond to direct verbal communication in person, on the phone, or via messages left on my confidential voicemail. This practice is to promote healthy, direct expression of thoughts and feelings, to facilitate accurate understanding of what is being communicated, and to protect patients' privacy. Your signature indicates your understanding of this communication policy.

_______________________________________ _______________________________

Signature of Responsible Party Date