

Child/Adolescent Intake

Western Reserve Psychological Associates, Inc.

Date of Initial Visit _____ **WRPA Therapist** _____

Minor's Name _____ Birthdate _____ SSN: _____

Address _____ Phone: _____

Street _____ City _____ State _____ Zip _____

Male _____ Female _____

Client Status: Employed _____ Full Time Student _____ Part Time Student _____

School currently attending _____ Grade _____ Religion _____

Father Name _____ DOB: _____ SSN: _____

Address if different from the child _____

Home Phone _____ OK to call? Yes _____ No _____ Cell Phone _____ OK to call? Y _____ N _____

Work Phone _____ OK to call? Yes _____ No _____

Employer _____

Employment address _____

Street _____ City _____ State _____ Zip _____

Mother Name _____ DOB: _____ SSN: _____

Address if different from the child _____

Home phone _____ OK to call? Yes _____ No _____ Cell Phone _____ OK to call? Y _____ N _____

Work phone _____ OK to call? Yes _____ No _____

Employer _____

Employment address _____

Street _____ City _____ State _____ Zip _____

Names and ages of child's siblings (if applicable): _____

Person responsible for deductible, coinsurance, and copayments (This will be the person who brings the child in and also signs the financial responsibility form): _____

Address _____

Street _____ City _____ State _____ Zip _____

Did you contact your insurance company to verify your benefits and let them know you were coming? _____

Deductible/year \$ _____ Has it been met? _____ Copayment/coinsurance/visit \$ _____ or _____ %

Did you receive an authorization number from your insurance company? Yes _____ No _____

Authorization number _____ Number of visits _____

Did you get a referral from your Primary Care Physician if required by your ins. co.? Yes _____ No _____

	Insurance Information		For Secondary Ins. Only
Policy Holder's ID/SS#	_____	Policy Holder's ID/SS#	_____
Ins Co. Name	_____	Ins. Co. Name	_____
Policy Holder's Name	_____	Policy Holder's Name	_____
Relationship to client	_____	Relationship to client	_____
Policy Holder's Address	_____	Policy Holder's Address	_____
Policy/Group #	_____	Policy/Group #	_____
Policy Holder's DOB	_____	Policy Holder's DOB	_____
Male _____ Female _____		Male _____ Female _____	
Employer	_____	Employer	_____

How did you hear about our practice? _____

When you decided to call us, where did you get our phone number? _____

May we thank your referral source? Yes _____ No _____ If yes, referral address _____
Did you search for more information about us on the internet? _____
Did you use a search engine? Yahoo _____, Google _____, AltaVista _____, Other _____
Did you visit our website? _____ For what purpose? _____
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Client Name _____ **Date** _____

Have you received mental health care previously? Yes _____ No _____
If so, name of therapist or group? _____
When? _____
What issues were addressed?

In your own words, what issues bring you here at this time?

Describe academic functioning (learning problems): _____

Describe any major medical/physical problems:

List known allergies:

Primary Care Physician _____ Phone: _____
Address _____
Date of last visit _____

List current medications prescribed by this doctor:

Medication	Daily Dose	Condition	Starting Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychiatrist, if applicable _____ Phone: _____
Address _____
Date of last visit _____

List current medications prescribed by this doctor:

Medication	Daily Dose	Condition	Starting Date
_____	_____	_____	_____

Nearest relative or friend (not spouse) we may contact in case of emergency:

Name	Relationship	Phone
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