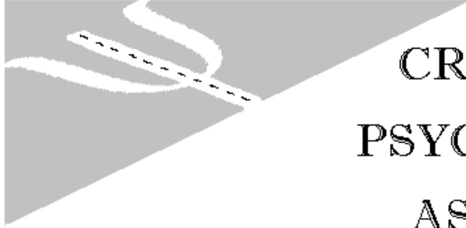

CROSSROADS
PSYCHOLOGICAL
ASSOCIATES

10784 HICKORY RIDGE ROAD • COLUMBIA, MD 20144-3646
PH. 410/964-0425 FAX 410/964-0515

Intake Questionnaire – Child

Client's Name ________________________________ *Date of Birth*____________________

Name of person completing Questionnaire ________________

Relationship _______________________

In the case of parental divorce only: Do you have authority to provide consent for this child's treatment? Yes / No

1. Please provide a brief statement explaining why you have scheduled this appointment:

2. Has this client previously been in therapy/counseling? Yes _____ No ____

   Name of Provider ____________________________ Dates of service ______________

   Name of Provider ____________________________ Dates of service ______________

Please indicate who lives with the client, their age, and the client's relationship to that person (e.g., parent, sibling). If there are multiple homes, please indicate the visitation schedule.

Has the client been diagnosed with a medical or neurological problem? Yes _____ No ____

If yes, please indicate the diagnosis(es)

____

If yes, is the client currently receiving services for the problem? Yes _____ No ____

Has the client been hospitalized for psychiatric reasons? Yes _____ No ____

If yes, when _____________________ and where _________________________________

Additional: when ____________________ and where _________________________________

What psychiatric medications is the client currently prescribed? None _________

Name of medication	Dose	Compliant? (Always, Sometimes, Rarely)

7. What non-psychiatric medications are being prescribed at this time? None _________

Name of medication	Dose	Compliant? (Always, Sometimes, Rarely)

8. What psychiatric medications have been prescribed in the past? None ________

Name of Medication	Dose	Dates Used	Why was Medication Ended?

9. Does this client have an active IEP/504 at his/her school? Yes _____ No ____

10. Please indicate with a 'check' those issues concerning to this client; you may use more than one check as a means of indicating the severity of the problem:

	Depression – sad, unhappy		Shy/few friends
	Anxiety – nervous, worries a lot		Anger
	Defiant/breaks rules		Aggressive with others
	Fearful		Poor concentration
	School problems (i.e., grades)		Few interests
	Low self-esteem/lacks self-confidence		Gets teased a lot
	Physical complaints		Destroys things
	Quickly changes moods		Threatens to hurt/kill him or herself
	Drug/alcohol use		Dependent – Insufficient autonomy
	Inattentive – easily distracted		Homework problems
	Easily irritated – grumpy a lot		Ongoing conflict between parents
	Parents have or may divorce		Unusual or bizarre behavior
	Adoption issues		Poor social skills
	Disorganization		Emotional/Physical/Sexual Abuse
	Disrespectful to authority		Isolative – prefers to be alone
	Cuts or otherwise harms him/herself		Problems with weight/regulating food
	Sexual Problem		

11. How did you hear about our practice?
_____ Friend/Family member
_____ Psychologist/Psychiatrist/Social Worker
_____ Pediatrician/Medical Doctor
_____ Other (please describe) _________________________________

(optional) The name of the person who referred you ______________________

PLEASE PRINT CLEARLY

CLIENT INFORMATION: ____

last name *first* *middle initial*

ADDRESS____

Street # *city* *state* *zip*

Phone: Home (_____) __________________Work (____) ____________________ Cell # (____) ______________________

Email Address (Optional):____________________________________ Preferred means to contact patient _______________

MARITAL STATUS_________ GENDER________ D.OB. _______/_______/_______ AGE_______

EMPLOYER/SCHOOL______________________________OCCUPATION/GRADE________________________________

REFERRED BY ____

If Patient is under 21 years of age, please complete the following for any information not already included above.
By providing this information, permission is given to Crossroads Psychological associates to contact the below named individuals.

Mother's Name________________________DOB: ________ Father's Name________________________DOB: ____________

Address ____ Address ____

____ ____

H (___) _____________Cell (___) __________ H (____) _____________Cell (____) ___________________

W (___) _____________Employer: ___________ W (____) _____________ Employer: ____________________

Email Address (Optional):___________________________ Email Address (Optional):__________________________________

I understand that unless other arrangements are made, ***all fees are due and payable at the time of service****. If in the event my account is turned over to a third party, I understand I'll be responsible for all collection fees, interest, court cost and attorney's fees. Insurance benefits will be filed as a courtesy and I agree to accept financial liability for all charges,* ***including missed appointments with less than 24 hours notice****. I authorize the release of any information necessary to process my insurance claims with my carrier. Any statement balance billed is due and payable upon receipt or a finance charge of 1.5% will be added monthly to the unpaid balance until the debt is discharged.*

GUARANTOR/PATIENT SIGNATURE: ***DATE:***

***If you want us to file for Insurance benefits as a courtesy on your behalf (benefits payable to the Insured), please provide your card and complete the following:**

____

(Who is the insured)? *(D.O.B.)* *SSN#* *(Relationship to patient)*

FOR OFFICE USE ONLY

CHART _________________ DIAGNOSIS___________ FEE $___________ COPAY__________ THERAPIST________________

Assigned to patient ___Yes or ___No Cash Patient ______