

Cornerstone Clinic *Medical & Counseling Center*

Child & Adolescent Intake Questionnaire

Your name: _____ Name of child: _____

Your SS# _____ Child's SS# _____

Your date of birth: _____ Child's date of birth _____

Your work phone #: _____ Child's work phone #: _____

Your home phone #: _____ Child's home phone #: _____

Your cell phone #: _____ Child's cell phone #: _____

To respect your privacy, we need a confidential phone number: _____

Your relation to child: Mother Father Grandparent Guardian Other

Insurance Information

Insurance Provider: _____ Address: _____

Insurance Phone #: _____ I.D. # _____

Group I.D. # _____ Other information _____

Child's General Information

Name: _____ Child's address: _____

Gender: Male Female Race: _____ Age: _____

Name of parent or legal guardian: _____

Parent or guardian's address: _____

Contact in case of emergency: _____ Relationship _____

Work phone: _____ Cell phone: _____ Home phone: _____

Thank you for choosing Cornerstone Counseling Center. We appreciate you taking the time to fill out this form in its entirety. Your answers on the following pages will help us give you and your child the best possible care.

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**Rate the items which your child is currently having problems.
Check the number that best indicates the existence or severity of the problem.**

0=none 1=minor 2=moderate 3=significant 4=serious

Check the word or words that best define each statement

Anxiety <input type="radio"/> worry <input type="radio"/> fear <input type="radio"/> panic <input type="radio"/> phobia	0	1	2	3	4
Feelings of <input type="radio"/> depression <input type="radio"/> sadness	0	1	2	3	4
Thoughts <input type="radio"/> death <input type="radio"/> suicide	0	1	2	3	4
Sleep Disturbances <input type="radio"/>	0	1	2	3	4
Mood Swings <input type="radio"/>	0	1	2	3	4
Grief over <input type="radio"/> death of loved one <input type="radio"/> major loss	0	1	2	3	4
Issues related to <input type="radio"/> pregnancy <input type="radio"/> abortion	0	1	2	3	4
Sexual abuse <input type="radio"/> incest <input type="radio"/> rape	0	1	2	3	4
Parental <input type="radio"/> alcohol <input type="radio"/> drug problems	0	1	2	3	4
Problems with <input type="radio"/> siblings <input type="radio"/> parents <input type="radio"/> friends	0	1	2	3	4
Problems with <input type="radio"/> work <input type="radio"/> school <input type="radio"/> legal	0	1	2	3	4
Sexual <input type="radio"/> concerns <input type="radio"/> problems	0	1	2	3	4
Problems with <input type="radio"/> alcohol <input type="radio"/> drugs <input type="radio"/> smoking	0	1	2	3	4
Feeling of <input type="radio"/> hopelessness <input type="radio"/> helplessness <input type="radio"/> despair	0	1	2	3	4
Memory <input type="radio"/> forgetfulness <input type="radio"/> changes	0	1	2	3	4
Reports being watched	yes	no			
Reports hearing voices when no one is around	yes	no			
Reports faces appear distorted	yes	no			
Reports colors appear to be bright or faded	yes	no			
Has the child ever attempted suicide	yes	no			

State in your own words what has brought your child to counseling: _____

Child's Family History:

Who does the child currently live with? _____

Child's birth order (check): 1 2 3 4 5 6 7

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Ages of siblings _____

Religious orientation: _____

Cultural beliefs: _____

Has the child been separated from his biological father or mother? _____

IF yes, for how long and under what circumstances: _____

Child's Social History:

How many close friends does your child have? _____ If possible give name(s), age(s), gender(s) and their relationship. (i.e. school friend, teammate, neighbor etc.) _____

Does your child prefer to play alone or with others? _____

What are your child's interests, hobbies, and recreational activities? _____

Academic and Work History:

Current grade: _____ Current school: _____

Primary teacher (if have): _____ School counselor: _____

Please list past schools: _____

Has your child had any academic problems or skipped a grade? ___ Yes ___ No

If yes, please describe. _____

How is your child currently performing in the following areas? (i.e. A, B, C, D, or F)

___ Math ___ Science ___ Reading ___ Writing ___ English ___ Social Science

___ History ___ Physical Education

What behavioral problems has your child had in school? (please check)

___ None

___ Truancy Please describe: _____

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- Fighting Please describe: _____
- Uncooperative Please describe: _____
- Other Please describe: _____

Is your child presently employed? _____ If yes, where and how many hours? _____

Past employment: _____

Medical History:

Name of child's current physician: _____ Phone: _____

Date of last examination or physical: _____

Has your child ever been hospitalized? Yes No If yes, please describe all occurrences and reasons. _____

Does your child have any of the following medical conditions?

- | | | |
|----------------------------------|--------------------------------------|--|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Anemia | <input type="radio"/> Asthma |
| <input type="radio"/> Allergies | <input type="radio"/> Brain injuries | <input type="radio"/> Cancer |
| <input type="radio"/> Colic | <input type="radio"/> Dizziness | <input type="radio"/> Ear infections |
| <input type="radio"/> Headaches | <input type="radio"/> Head injuries | <input type="radio"/> Hearing problems |
| <input type="radio"/> High Fever | <input type="radio"/> Influenza | <input type="radio"/> Pneumonia |
| <input type="radio"/> Seizures | <input type="radio"/> Skin problems | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Vision | <input type="radio"/> Other | |

Please briefly describe any checked medical conditions: _____

List all medications taking for the checked conditions: _____

List any diets or exercise programs: _____

List any other medical problems and associated medications: _____

Legal History:

Has your child ever had any legal problems? _____ If yes, please describe, when it occurred, where it

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occurred and what was it over. _____

Does your child have a probation officer? _____ If yes, name and phone number: _____

Substance Use:

History: Yes No

Current: Yes No

Substances: _____

Frequency: _____

Amount: _____

Longest period of sobriety: _____ Length of use: _____

Prior treatment: _____

To the best of my knowledge the information provided is accurate and true.

I agree to counseling treatment for my child at Cornerstone Clinic, Medical & Counseling Center.

Signature of custodial parent(s):

Date: _____ Signature: _____

Date: _____ Signature: _____

Signature of noncustodial parent:

Date: _____ Signature: _____

Other parent not available: (Comment) _____

Cornerstone Clinic *Medical & Counseling Center*

Information and Informed Consent

(Please initial on line indicating you read the paragraph)

Introduction

Cornerstone Clinic is committed to treating you as a whole person, body, soul and spirit. We provide counseling services to help nurture you to become a healthier individual in all three of these areas. Our trained professionals are skilled in pastoral and clinical counseling and are here to serve you. Thank you for coming to Cornerstone Clinic!

Confidentiality

We place a high value on confidentiality and we will make every effort to ensure that your information will be kept confidential. Because we endeavor to be the best we can, we occasionally bring client cases to case consultation. Should we discuss your case, we will not mention your name. You should be aware however, that legal requirements specify certain conditions in which it is necessary for us to disclose your name and/or your treatment. These requirements are:

1. If we believe you are a danger to yourself or others.
2. If we become aware of any involvement you have in the abuse of children, elderly, or disabled persons.
3. If we are ordered by a judge or court to release your records.

Fees

The current fee for receiving counseling at Cornerstone Clinic is \$125 for the first fifty-minute intake/ diagnostic interview, and \$110 per fifty minute session for each follow-up visit. These fees are due at the time of your visit. These fees also apply to the preparation of assessment reports, telephone conversations, consultations, or meetings you have authorized as part of your counseling process. If you have insurance, we will bill your primary carrier as a courtesy. **However, if insurance does not pay, you are responsible for your bill.** Fees can be arranged based on review of a financial disclosure form; for further information, inquire at the front desk. At times, we also participate in the training of graduate students who may intern here. Fees for services with interns are different from our hourly rate and the front desk receptionist will explain the fees to you.

Client Responsibility

If, for some reason, you cannot attend a scheduled session, please give us 24-hour notice of cancellation. There will be a thirty dollar (\$30) charge for the first missed appointment with failure to either cancel within 24 hours or show for a scheduled appointment. The full fee of \$110 will be charged for second and subsequent missed sessions. Consistent failure to cancel within 24 hours, not show for an appointment or to keep account(s) current may result in termination or referral. Please be as committed to us as we are to you.

Consent is hereby given CHA/Cornerstone Clinic to administer treatment deemed necessary.

I also consent to the release of information for insurance purposes from my insurance company to Cornerstone Clinic. This signed consent shall remain in effect until it is revoked by patient or guardian, at which time written notice must be given to withdraw existing consent.

I am responsible for all charges generated for services rendered, including services not covered by my insurance company.

I have read this document and agree to participate in my treatment under the conditions described above.

Signature _____ Date _____