

Willamette Valley Family Center, LLC

610 Jefferson Street - Oregon City, Oregon 97045 ---- Phone (503) 657-7235 Fax (503) 657-7676

CHILD INTAKE EVALUATION - (To be completed by parents)

1. IDENTIFYING INFORMATION

| | | |
|---------------------|---------------------|--------------------|
| Child's Name: _____ | Today's Date: _____ | Referred By: _____ |
|---------------------|---------------------|--------------------|

Gender: M F Age: _____ Birth Date: _____ Social Security (ID) #: _____
mm/dd/yyyy

Custodial Parent Name: _____ E-Mail Address _____

Home address: _____
Street City State Zip

Telephone: _____
(home) mother (cell) father (cell)

Reminder Call Preference : Text # _____ Automated Voice Call Office Staff to Call NO CALL

School Child Attends: _____ Grade in School: _____ Phone: _____

Others living in the home: _____
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

(name, birthdate, relationship to client) (name, birthdate, relationship to client) (name, birthdate, relationship to client)

Immediate family living outside the home: _____
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

Emergency contact: _____ Phone: _____

Insurance Information

Name of subscriber: _____ Insured date of birth: _____
mm/dd/yyyy

Address of subscriber: _____
Street City State Zip

Relationship of client to subscriber: _____

Insurance Company: _____ Phone: _____

Insurance Company Address: _____
Street City State Zip

Insurance Identification Number: _____ Group Number: _____

Employer of subscriber: _____

Secondary insurance: _____ Phone: _____

Name of secondary subscriber: _____ Date of Birth: _____
mm/dd/yyyy

Secondary company address: _____
Street City State Zip

Secondary identification number: _____ Group number: _____

Employer on secondary subscriber: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to provider of services.

Signature (Insured) Date

2. PRESENTING PROBLEM

Describe the child's problem (s) that brought you here today:

| Check any of the symptoms that the child has been having: | | | |
|---|--|-------------------------------------|--|
| Depressed mood | | Feels hopeless | |
| Extreme sadness | | Tearful/crying spells | |
| Trouble concentrating | | Memory problems | |
| Change in sleeping habits | | Lack of energy | |
| Security blanket or object | | Stuttering | |
| Bedwetting | | Thumb sucking | |
| Change in eating habits | | Weight/appetite changes | |
| Problems getting along with family | | Problems getting along with friends | |
| Doesn't seem to enjoy usual activities | | Feelings of extreme happiness | |
| Trouble doing schoolwork | | Truancy | |
| Feeling stressed | | Irritability | |
| Low self-esteem | | Isolation/withdrawal | |
| Perfectionistic | | Expressed feelings of guilt | |
| Worries | | Seems nervous | |
| Feeling fearful | | Sudden feelings of panic | |
| Physical complaints of pain | | Tense/uptight | |
| Anger outbursts | | Acting violently | |
| Running away | | Harm to animals | |
| Has hurt or cut on themselves | | Fire setting | |
| Thoughts of killing self | | Thoughts of killing others | |

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3. WHAT HAS BEEN DONE ABOUT THIS PROBLEM SO FAR?

Have you worked with the child's teacher or school counselor? Yes No

If you have, please describe it below

| | |
|-------------------------------|-----------|
| Name of teacher or counselor: | Date (s): |
| | |

Has this child been in counseling before? Yes No

If the child has been in counseling before, please describe it below, starting with the most recent first.

| | |
|-----------------------------|-----------|
| A. When was the counseling? | Date (s): |
| Who did you see? | Name: |
| Explain what happened: | |
| | |
| B. When was the counseling? | Date (s): |
| Who did you see? | Name: |
| Explain what happened: | |
| | |

Has the child been prescribed any psychiatric medications? Yes No

If yes, please describe:

Date (s):

| | |
|--|--|
| | |
|--|--|

4. SUBSTANCE USE HISTORY (If Applicable)

| | | | | |
|---|----------------------------------|------------------------------------|-------------------------------|-----------------------------|
| Does the child use tobacco (any form?) | Current <input type="checkbox"/> | Suspected <input type="checkbox"/> | Past <input type="checkbox"/> | No <input type="checkbox"/> |
| Does the child use alcohol? | Current <input type="checkbox"/> | Suspected <input type="checkbox"/> | Past <input type="checkbox"/> | No <input type="checkbox"/> |
| Does the child use caffeine (any form including cola drinks)? | Current <input type="checkbox"/> | Suspected <input type="checkbox"/> | Past <input type="checkbox"/> | No <input type="checkbox"/> |
| Does the child use recreational drugs? | Current <input type="checkbox"/> | Suspected <input type="checkbox"/> | Past <input type="checkbox"/> | No <input type="checkbox"/> |

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5. MEDICAL INFORMATION

| | | |
|--|------------------------------|-----------------------------|
| Has the child seen a doctor within the last year? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| What was that for? | | |
| Who is the child's doctor? | Phone: | |
| Is the child taking any medications (prescription or over-the-counter)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Please list any medications that the child is taking: | | |
| Please list any major medical problems that the child has had such as a chronic illness, serious illness, operations, injuries or trauma to the head, etc.: | | |
| Does the child have allergies to anything? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Describe any allergy problems that he or she may have: | | |
| Does the child have problems with sleeping? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Does the child have any problems with eating? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Does the child have any problems with toileting? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Describe the problem(s): | | |
| Has the child been affected by any issues such as witnessing violence, having accidents, experiencing loss, or experiencing abuse (physical, sexual or emotional). Please describe the relevant issue(s): | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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6. DEVELOPMENTAL HISTORY

| | | |
|--|------------------------------|-----------------------------|
| Were there any problems with the pregnancy or the delivery of the child? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any problems with eating, sleeping or crying spells, colic, nightmares, etc.? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Did the child demonstrate any difficulties or delays in walking, talking, and toilet training? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Has there been any family crisis such as marital separation or divorce? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have there been any mental health problems in the family of origin? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have there been any substance use or abuse issues in the family? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Briefly describe the child's relationship to parents: | | |
| | | |
| Briefly describe the child's relationship to siblings: | | |
| | | |
| Briefly describe the child's temperament: | | |
| | | |

7. SCHOOL HISTORY

| | | |
|--|------------------------------|-----------------------------|
| When did the child start school? | | |
| Were there any problems when the child started school? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| What problems have come up during the school years? | | |
| | | |
| What grades is the child getting? | | |
| | | |
| Describe any changes in the child's school performance: | | |
| | | |
| How does the child get along with his or her teachers? | | |
| | | |
| How does the child get along with his or her friends or peers in school? | | |
| | | |
| What are the child's favorite subjects or school activities? | | |
| | | |