Jessica Long, Psy.D.

Licensed Psychologist

Client Intake Information - MINOR

Client Information

Client's Name: Last ____________ First ____________ Middle ______

Address: ____________ City: ____________ State: ______ Zip: ______

DOB ____________ Age at Intake ________ Grade: _______ ☐Male ☐Female

I give my permission to be contacted at the below telephone numbers/email:

Home ____________ Work ____________

Cell ____________ Email ____________

Messages can be left at: ____________

Parent Information

Name: Last ____________ First ____________ Middle ______

Address: ____________ City: ____________ State: ______ Zip: ______

Phone: Home ____________ Cell/Work ____________ DOB ____________ ☐Male ☐Female

Occupation ____________ Place of Employment: ____________

Name: Last ____________ First ____________ Middle ______

Address: ____________ City: ____________ State: ______ Zip: ______

Phone: Home ____________ Cell/Work ____________ DOB ____________ ☐Male ☐Female

Occupation ____________ Place of Employment: ____________

Insurance Information

Primary Insurance Co.	Ins. Phone #
Member ID	Group #
Insured's Name	Relationship to Client
Insured's DOB	Insured's SS #
Insured's Address	Insured's Phone

**Please note, we do not bill secondary insurance but can provide you with documentation to submit to your secondary insurance company.*

Office Use Only: ☐ Copy of Ins. ☐ Add. & Ins. Inf. Complete ☐ Rating Scale Form ☐ Consent signed ☐ ROI School ☐ Reminders ☐ Copies made

Have you contacted your insurance company to verify your mental health benefits? ☐Yes ☐No

If yes, is Jessica L. Long, Psy.D. an in-network provider for your insurance? ☐Yes ☐No

If *no*, are out of network benefits available? ☐Yes ☐No

If *yes*, do you need prior authorization? ☐Yes ☐No # of sessions allowed? ______

Do you have a deductible? ☐Yes ☐No

If *yes,* what amount? _______ *or* amount you have already reached ?______

Do you have a co-pay or co-insurance? ☐Yes ☐No If *yes,* what amount? ________

Person Completing This Form: ______________________ Relationship: ____________________

Primary reason you are seeking services for yourself/your child? ____________________________________

Who referred you to our office? ____________________________________

About Your Child's Home & Family

Primary Language Spoken in Home: ______________________________

Religious/Spiritual Affiliations? ______________________________

Cultural Factors for Consideration? ______________________________

Persons who live **in the home** with the child:

Name	**Gender**	**Age**	**Relationship**
	Male Female		Guardian Biological Parent Adoptive Parent Foster Parent Grandparent Step-parent
	Male Female		Guardian Biological Parent Adoptive Parent Foster Parent Grandparent Step-parent
	Male Female		Sibling Other:
	Male Female		Sibling Other:
	Male Female		Sibling Other:
	Male Female		Sibling Other:
	Male Female		Sibling Other:

Persons close to the child who **do NOT live in the home**:

Name	Gender	Age	Relationship
	Male Female		
	Male Female		
	Male Female		

Do both parents live in the home with the child? Yes No
If **No**, Please explain:

Are there any legal issues that affect your child (i.e. divorce, adoption)? Yes No
If **Yes**, Please explain:

During the past 12 months, has your family experienced any of the following?

Death of a family member   Serious illness   Unemployment   Marital problems

Moved Residences   Family member move away   Other:

Family History		Relationship to client	Notes:
Mental Retardation	Yes No		
Speech-Language Delays	Yes No		
Learning Disabilities	Yes No		
Autism Spectrum	Yes No		
Attention Deficit/Hyperactivity Disorder	Yes No		
Depression	Yes No		
Bi-polar	Yes No		
Obsessive Compulsive Disorder	Yes No		
Anxiety Disorder	Yes No		
Schizophrenia	Yes No		
Other:	Yes No		

Social/Emotional/Behavioral History

Is the child currently seen for counseling or therapy? Yes No
If **yes**, please explain:

Prior Mental Health Diagnoses?

What are your child's strengths?

What does your child enjoy doing to occupy his/her free time?

What areas are you most concerned about for your child?

Early Developmental History

Was the pregnancy with your child full term? Yes No
If No, please explain:

Were medications, alcohol, or cigarettes used during pregnancy? Yes No
If yes, please explain:

Were there any complications during the pregnancy and/or delivery? Yes No
If yes, please explain:

Child's weight at birth: lbs. oz.

When did your child Independently? Age in months:

Milestone	Age in months
Begin sitting up	
Begin Crawling	
Begin walking	
Say his/her first meaningful word	
Put 2-3 words together	
Toilet Train (urinary)	
Toilet Train (bowel)	

Did you feel OR were you told that your child was delayed in achieving the above developmental milestones?
Yes No ***If Yes**, please explain:* ____

Does your child smile in response to your smile? Yes No

Does your child approach other children to play? Yes No

Does your child appropriately greet familiar others? Yes No

Does your child have difficulty with eye contact? Yes No

Does your child have difficulty with transitions or changes in routine? Yes No

Does your child display any behaviors you feel are atypical for children of his/her age? Yes No

How does your child cope with upset/stress?

Does your child have any unusual sensory responses to noise, touch, smell, taste, etc.? Yes No

Medical History

Pediatrician's Name:	Phone #:
Office Address:	
Date of Your Child's Last Physical:	

Does your child have any Vision or Hearing Impairments? (Please specify)

Has your child been diagnosed with any other medical problems? Yes No

If **yes**, please describe below:

Diagnosis	Doctor who made diagnosis	When was the diagnosis made?

Has the child ever been hospitalized for an injury or illness? Yes No

If **Yes**, please explain:

Has your child experienced any chronic or severe illnesses? Yes No

If **Yes**, please explain:

Current Medications	Dosage	Reason for prescription	When child began medication	Doctor who prescribes

School History

Did your child go to preschool? Yes No
If yes, at what age(s) did your child attend?
And where?

Where is your child currently enrolled in school?

What grade is he/she in?

Is your child on an Individualized Education Plan (IEP) or 504 plan? Yes No

If yes, under what category of special education:

Please list all schools your child has attended in the order in which he/she attended those schools.

School	Age(s)	Grade(s)	School District

Interventions	**School or Privately?**	**What ages?**
Speech-Language Therapy	School Private	
Occupational Therapy	School Private	
Physical Therapy	School Private	
Behavior Therapy	School Private	
Social Skills Therapy	School Private	
Counseling	School Private	
Evaluations	School Private	

Anything else you feel we should know about your child that has not been asked?

Client Name: ________________________ Dob: _______

Acknowledgement of Office Policies, Privacy Practices,
Consent for Treatment & Payment Responsibility

I have received a copy and had the opportunity to review the Office Policies, Electronic Communications Policy, Client Rights, and Privacy Practices provided to me by Jessica Long, Psy.D. I have had the opportunity to have answered any questions I might have about these policies.

I give my permission for Jessica L. Long, Psy.D. to provide treatment to me or my child.

I have read and understand the Financial Agreement information contained in this form. I certify that the information I provided is correct to the best of my knowledge and I acknowledge that I am responsible for payment of the services rendered by Jessica Long, Psy.D. If I choose to use insurance coverage, my co-payment and/or percentage of the bill are due at the time of service. I authorize Jessica Long, Psy.D. and her administrative and billing staff and/or any collection agencies used by Jessica Long, Psy.D., to contact me by phone and/or mail for billing activities or payment arrangements.

If I am 13 or older, I understand that I have a right to seek and consent to outpatient mental health treatment without a guardian (according to Washington law, RCW 71.34.530). However, I also understand that regular parent/guardian involvement is an important part of my treatment.

I also give consent for Jessica L. Long, Psy.D. and her office staff to communicate with my parents or legal guardians regarding financial and procedural (i.e., scheduling, missed appointments) information. I also understand that information gathered during a psychological or psycho-educational assessment will be included in the written report and shared with my parents or legal guardians.

________________________________ ________________
Client Signature (if 13 years old or above) Date

________________________________ ________________
Parent/Guardian Signature (for all minors) Date