Date_____ **CHILD**

Name_____Birth date_____ Sex M F

Last First MI

Soc Sec # _____ Age_____

Address _____

Parent(s)/Guardian Names/Addresses/Phone

Mother_____

_____

Father_____

_____

Work Phone (Mother's)_____Father's_____

Emergency Contact / Phone #/ Relationship to client _____

Primary Care Physician _____ Phone # _____

School _____ Grade _____

Insurance Co _____

Group # _____ ID # _____

Name/DOB of person who carries insurance _____

Relationship to Client _____

Who referred you to the Acacia Center? _____

What problems is your child experiencing? When did they start? _____

____ Depression/sadness/tearfulness ____ Worry/stress/anxiety/panic/fear ____ Anger Problems

____ Family/relationship issues ____ Social/School problems ____ Poor appetite/overeating

____ Activity level/behavior problems ____ Poor sleep ____ Legal problems ____ Sexuality

____Other (describe) _____

Does your child have thoughts of not wanting to live? Hurting himself? Hurting someone else? Has he/she ever attempted suicide, hurt him/herself on purpose, or overdosed? _____

Does he/she have any medical problems that significantly affect his or her life? Yes/No _____

_____

Does your child use tobacco in any form? ____ If yes, how much per day? _____

Does he/she drink alcohol? _____ If yes, how many drinks per day? _____

Does your child use illegal drugs, or misuse prescribed drugs? _____

# and ages of siblings _____

Who else lives in the home? _____

Is your child in Special Ed? _____ Any problems getting along at home or at school? _____

_____

Has he/she experienced emotional, physical, or sexual abuse, neglect, removal from home, or death in the family as a child? _____

_____

Has your child ever been in counseling or mental health treatment before? Yes No

Reason _____

Where and when has he/she received treatment previously? _____

_____

_____

This questionnaire is about how your child has been feeling recently. If your child is 12 or older, please have him or her fill it out.

Please check the box that describes how you have been feeling over the past two weeks.

| | Not true | Sometimes true | True |
|---|---|---|---|
| I felt miserable or unhappy | | | |
| I didn't enjoy anything at all | | | |
| I felt so tired I just sat around and did nothing | | | |
| I was very restless | | | |
| I felt I was no good anymore | | | |
| I cried a lot | | | |
| I found it hard to think properly or concentrate | | | |
| I hated myself | | | |
| I was a bad person | | | |
| I felt lonely | | | |
| I thought nobody really loved me | | | |
| I thought I could never be as good as other kids | | | |
| I did everything wrong | | | |

**Current Medications/Dosage (continue on back if necessary)** **Prescribing physician**

_____

_____

_____

_____

_____

_____

_____

Any significant side effects? _____

_____

Application for Services

I hereby voluntarily request care and treatment for _____ by Dr. D. Shaner Gable, Ph.D., H.S.P.P., Dr. Carolyn B Hines, Ph.D., or one of the therapists under their supervision. I am authorizing Drs. Gable and Hines or one of their mental health professionals to administer such treatment as may be deemed necessary and/or advisable. I understand that I have the continuing right to explanation of the nature and purpose of the treatments as well as possible alternative methods and possible risks involved. I also understand that I may voice any dissatisfaction with treatment without penalty, and may request a change of therapist or refuse any treatment offered.

I acknowledge that I have been given opportunity to review the HIPAA policies of the Acacia Center and to request a copy of such policies.

Although every effort will be made to obtain payment from my insurance company, in the event that the insurance company denies payment, I understand that I will be responsible for the full amount not paid. I understand that I am financially responsible for any co-pays and/or deductibles set by my insurance company, and that co-pays are due the day of service. I give consent for release of any medical records to my insurance company that are necessary to facilitate reimbursement, and that this consent is valid for the duration of my treatment at Acacia Center.

If I am covering the therapy expenses independently, I agree to pay $ _____ for the first session and $ _____ for each follow up session, as determined by the therapist and the Acacia Center. This payment is due at time of service.

I understand that, if I must cancel a scheduled appointment, a 24 hour notice is expected. I understand that a fee may be charged for late cancellations or failed appointments. I further understand that a pattern of failed appointments may result in discharge from the care of Acacia Center.

Client Signature _____

Printed Name _____ DOB _____

Date _____