Welcome! Thank you for choosing SPSI for your healthcare needs. To help us help you, please fill out this form to the best of your ability. If you have any questions, our staff will be happy to help.

CLIENT INFORMATION

Name: ______________________ Date of Birth: __________ Soc Sec #: __________
Last First Middle

Gender: M F Race: __________ Marital Status: ○ Single ○ Married ○ Widowed ○ Separated ○ Divorced

Phone Number: ( ) __________ Alternate Phone: ( ) __________ This is my (_____________) phone

Address: ______________________________
Street Apt, Suite, etc. City, State ZIP

Employed By: __________________ Occupation: __________

Work Address: __________________ Work Phone: __________

Who may we thank for referring you? How did you learn of our practice? __________

Where do you prefer to receive calls? __________ Any special instructions regarding telephone calls? __________

When is the best time to reach you? Days: __________ Times: __________

EMERGENCY CONTACT INFORMATION

Contact person: __________ Relation: __________ Home #: __________ Work #: __________

Name of Primary Physician: __________ Phone: __________ Hospital: __________

Date of Last Physical Exam: __________ Medical Conditions: __________

Allergies: __________

RESPONSIBLE PARTY

Responsible Party: ______________________ Relation: __________ Date of Birth: __________
Last First Middle

Driver's License #: __________ Soc Sec #: __________ Phone: __________

Employed by: __________ Occupation: __________ Work Phone: __________

INSURANCE INFORMATION

	Primary Insurance	Secondary Insurance	Other Insurance
Effective Date			
Policy Holder			
Relation to Client			
Policy Holder Date of Birth			
Soc Sec #			
Employer			
Date Employed			
Occupation			
Ins. Company			
Group #			
Contract #			
Deductible Amount			

FINANCIAL ARRANGEMENTS

We ask payment in full at each appointment. For your convenience, we offer the following methods of payment. Please check the option you prefer:

○ Cash ○ Check ○ Credit Card ○ Payment Plan

Late Charges

If I do not pay the entire balance within 25 days of the monthly billing, I realize a late charge of 1.5% on the balance then unpaid will be owed and will be assessed monthly. I realize that failure to keep the account current may result in you being unable to provide additional services, except for emergencies or where there is prepayment for additional services.

ASSIGNMENT AND RELEASE

AUTHORIZATION, ASSIGNMENT, AND RELEASE

I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners or to persons designated as emergency contacts.

I assign directly to Saginaw Psychological Services, Inc. (SPSI) all medical benefits, if any, otherwise payable to me for services rendered. I understand that my insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, whether or not paid by insurance. I hereby authorize Saginaw Psychological Services, Inc. (SPSI) to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

______________________________ __________
Signature of Insured/Guardian **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Saginaw Psychological Services, Inc. (SPSI) for any services furnished to me by SPSI. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ __________
Beneficiary Signature Date

Saginaw Psychological Services, Inc.

CHILD/ADOLESCENT INTAKE

Client Name: ______________________________ Client #: ______________________ Date: ______________________

Age: ____ Gender: ○ Male ○ Female Responsible Party/Guardian: ____

Race: ○ Caucasian ○ African American ○ Hispanic/Latino ○ Native American ○ Asian ○ Other _______________

Description of Problems and Onset

State in your own words the nature of your child's main problem(s), i.e. the reason you are seeking professional assistance today.

Please check the box below that best describes the severity of the problem(s).

○ Mildly Upsetting ○ Moderately Upsetting ○ Very Severe ○ Extremely Severe ○ Totally Incapacitating

What do you hope/want counseling to accomplish? What will be different?

Has your child ever talked about or attempted suicide? ___ Yes ___ No *If yes, explain briefly.*

Have your child ever talked about hurting him/herself or done so? ___ Yes ___ No *If yes, explain briefly.*

Has your child ever talked seriously about hurting or killing someone/something or done so? ___ Yes ___ No *If yes, explain briefly.*

Does your child have any other risk-taking behaviors or concerns? ___ Yes ___ No *If yes, explain briefly.*

Has your child ever been in therapy before? ___ Yes ___ No *If yes, indicate the dates, place(s), type(s), purpose(s), and resultant diagnosis(es), of therapy he/she was involved in.*

From	*To*	*Location*	*Type/purpose of therapy/diagnosis*

Who else would you like involved in your child's treatment?

FAMILY, HOME, FINANCIAL INFORMATION

In the table below, please indicate the names and ages of your child's family (including parents, step parents, brothers, and sisters), whether they are still living, their history of substance abuse/mental health problems, the quality of their relationship with your child (i.e. do they have a good relationship), whether they live in the household with the child, and any additional comments you feel are necessary to accurately portray the relationship between them. If your child is being raised by a relative other than parents, please include them in the extra spaces provided as well as anyone else who may be living in the home with the child at this time.

Relation	**Name**	**Age**	**Living?** (Y/N)	**History of Substance Abuse or Mental Heath Problems?** (Y/N)	**Quality of Relationship**	**Live w/ Child?** (Y/N)	**Comments**
Mother							
Father							
Stepmother							
Stepfather							
__ Brother __ Sister							
__ Brother __ Sister							
__ Brother __ Sister							
__ Brother __ Sister							

Who is the legal guardian/custodial parent? ______________________ *If other than parents, please explain why briefly.*

____

Are you willing/able to participate in your child's treatment? ___ Yes ___ No

If applicable, does the non-custodial parent know of the child's appointment today? ___ Yes ___ No

If applicable, will the non-custodial parent be participating in the child's treatment? ___ Yes ___ No

Were your child ever physically, emotionally, or sexually abused? ___ Yes ___ No *If yes, please explain extent of abuse and person(s) involved*

____

____

Please indicate any other information you feel is necessary to understand your child's relationship with your family.

____

____

____

Do you feel your family is: ○ Lower Class ○ Middle Class ○ Upper Class

Does your family live in a(n): ○ Apartment ○ House ○ Trailer ○ Other (Specify) _________________________

Describe the neighborhood where your family lives.

____

____

What is the major source of the family's income? ____

History/Current Status

DEVELOPMENTAL HISTORY

Mother's pregnancy with child was: ○ Normal ○ Complicated (please explain) ______________________________

____

____

Please indicate whether any of the substances below were used during pregnancy and comment as necessary.

○ Tobacco ○ Alcohol ○ Drugs ○ Medications ______________________________

____

____

Please indicate below details regarding the delivery of your child and explain any complications in the space provided.

○ Full Term ○ Vaginal Delivery ○ C-Section ○ Premature ○ Fetal Distress ○ Complications (explain below)

____

____

Birth weight: _______ *lbs.* _______ *oz.* *Child's condition at birth was:* ○ Normal ○ Abnormal (please explain)

____

____

As an infant your child was:

○ Easy to manage ○ Irritable ○ Demanding ○ Alert/Responsive ○ A poor eater ○ A poor sleeper

Please indicate at what age your child reached the following developmental milestones.

________ Sat up unassisted ________ Walked without support ________ Used first words

________ Used sentences ________ Toilet trained (daytime) ________ Dry at night

Toilet training was: ○ Easy ○ Difficult *Does your child:* ○ Wet bed ○ Wet during day ○ Soil him/herself

Has your child ever had an imaginary friend or companion? ___ Yes ___ No

Have any of your child's physicians or teachers ever expressed any concerns about the following areas of development?

○ Language Development ○ Speech Development ○ Fine motor development ○ Behavior Problems

○ Hearing ○ Vision ○ Intelligence ○ Other (explain) ______________________________

SCHOOL HISTORY

Current School: ______________________ *Grade:* _____ *Teacher:* ______________________

Has your child/adolescent ever repeated a grade? ___ No ___ Yes (grades)

Is your child currently receiving special education services? ___ Yes ___ No *If yes, explain briefly (i.e. what services).*

____

____

In the table below, please indicate which school your child attended for each grade year and the average grades he/she received during that grade. Also indicate if he/she experienced any of the problems listed for each grade. Additional lines have been provided in the table if the child had to repeat a grade.

Grade	School/District	Average Grades	Problems Experienced: Learning Problems	Peer Problems	Behavior Problems	Suspension	Expulsion	Other (explain)
K			○	○	○	○	○	
1			○	○	○	○	○	
2			○	○	○	○	○	
3			○	○	○	○	○	
4			○	○	○	○	○	
5			○	○	○	○	○	
6			○	○	○	○	○	
7			○	○	○	○	○	
8			○	○	○	○	○	
9			○	○	○	○	○	
10			○	○	○	○	○	
11			○	○	○	○	○	
12			○	○	○	○	○	
			○	○	○	○	○	
			○	○	○	○	○	

Please indicate in the space provided below any additional comments regarding your child's school history or current school performance, behavior, grades, etc.

____

____

____

____

GENERAL BEHAVIOR

*Please check any items below which describe your child's typical behavior (how he/she is **most** of the time).*

○ Friendly & Outgoing ○ Shy ○ Cooperative ○ Stubborn ○ Respectful ○ Defiant

○ Easygoing & Calm ○ Irritable ○ Optimistic ○ Pessimistic ○ Confident ○ Expects Failure

○ Takes Risks ○ Cautious ○ Hard Working ○ Lazy ○ Caring ○ Uncaring

○ Sharing ○ Selfish ○ Happy ○ Unhappy ○ Prefers Company ○ Prefers to be alone

Please check any of the following behaviors which occur frequently now or in the past.

○ Worries	○ Misses School due to Illness	○ Destroys Property	○ Learning Problems
○ Fears	○ Frequent Physical Complaints	○ Sets Fires	○ Speech Problems
○ Obsessive Thoughts	○ Skips Classes/School	○ Cruel to Animals	○ Poor School Work
○ Compulsive/Repetitive Behavior	○ Legal Problems	○ Sexual Activity	○ Appetite Change
○ Odd Thoughts	○ Runs Away From Home	○ Reckless/Careless	○ Mood Swings
○ Odd Behavior	○ Tantrums/Angry Outbursts	○ Disruptive	○ Sadness
○ Disturbing Thoughts	○ Bullies	○ Messy	○ Depression
○ Nightmares	○ Argues	○ Accident Prone	○ Crying Spells
○ Night Terrors	○ Defiant/Oppositional	○ Short Attention Span	○ Irritability
○ Insomnia (Can't Sleep)	○ Fights	○ Distractible	○ Withdrawn
○ Sleep Walking	○ Lies	○ Impulsive	○ Boredom
○ Won't Sleep Alone	○ Steals	○ Hyperactive	

Please indicate in the space provided below any additional comments regarding your child's current or past behaviors.

____

____

____

____

SPIRITUAL

Does your family practice a religion? ___ Yes ___ No *If yes, what is your preferred religion?* ___________________

Is there anything you would like us to take into consideration regarding your religion while developing a treatment plan?

____

____

CULTURAL

As a family, do you identify yourself with a particular cultural or ethnic group? ___ Yes ___ No *If so, explain briefly.*

____

____

LEISURE / SOCIAL ACTIVITIES

How does your child spend his/her leisure time, what activities?

____

____

Does your child get along well with peers? ___ Yes ___ No *How many good friends does he/she have?* __________

MEDICAL

How is your child's current health? ___ Good ___ Fair ___ Poor *Currently in treatment?* ___ Yes ___ No

If your child is currently in treatment, or his/her health is other than good, explain briefly.

____

Current primary care physician: ___________________________________ *Last date seen:* ________________________

Are your child's immunizations up to date? ___ Yes ___ No

Indicate the dates of any serious illnesses, injuries, surgeries, or hospitalizations: ________________________________

____

Indicate any allergies your child may have: ____

____

Does your family have any significant medical history? ____

____

The following (Substance Abuse, Sexual Information, Work History) pertains primarily to older children/adolescents.

SUBSTANCE USE

Has your child ever used drugs or alcohol? ___ Yes ___ No *If yes, please fill out the table below. Indicate the substance name, the amount used, the frequency (e.g. daily, weekly, etc.) used, the first date of use, most recent use, and any comments you may have pertaining to the use of that substance.*

Substance	*Amount*	*Frequency*	*First Use*	*Last Use*	*Comments*

Do you believe your child has an alcohol or drug problem? ___ Yes ___ No *Drug of choice?* ______________________

Does your child smoke cigarettes? ___ Yes ___ No *How many per day?* ________________________________

Over-the-counter medication? ___ Yes ___ No *Which medication(s)?* ____

Is there anything else you would like us to know concerning your child's past or current alcohol / drug use?

____

____

SEXUAL INFORMATION

Is your child sexually active? ___ Yes ___ No *If yes, explain briefly.*

____

____

Has your child ever contracted a sexually transmitted disease? ___ Yes ___ No *If yes, explain briefly.*

____

Has your child been pregnant, or been in a relationship resulting in pregnancy? ___ Yes ___ No *If yes, explain briefly.*

____

____

HIV Assessment: Multiple sexual partners? ___ Yes ___ No *injected drug use?* ___ Yes ___ No

unprotected sex? ___ Yes ___ No *blood transfusion(s)?* ___ Yes ___ No

exposure to blood and/or blood products? ___ Yes ___ No

Please indicate any other specific concerns you may have regarding sexual matters (education, behavior, orientation, etc.) in the space provided.

____

____

WORK HISTORY

Indicate in the space provided any employment your child has or has had in the past along with the requested information.

Employer	Dates	Job Description	Comments

Has your child had any work related problems? ___ No ___ Yes (explain)

____

LEGAL

Is your child, or has your child been, involved in any civil or criminal legal proceedings? ___ Yes ___ No *If yes, explain briefly.*

ADJUSTMENT

Summarize briefly what sorts of things have changed in your child's life due to the current problem(s) for which you are now seeking care.

OTHER

If there is any other information you would like to provide us with that you feel may be relevant to your child's treatment and/or treatment planning here at SPSI, please feel free to make a note of it here.

Saginaw Psychological Services, Inc.

Medication Summary

Client Name: ______________________________ Client #: ______________________ Date: ________________

Is your child allergic to any medications? ___ Yes ___ No *If yes, indicate the names of the medications in the space provided below.*

____

____

Does your child take medications only as prescribed? ___ Yes ___ No

In the spaces provided below, please note ***each medication that your child is currently on, or has been on in the past*** *along with the requested information. Make sure to* ***also include any over-the-counter/non-prescription medications your child is currently on****. If you do not know a certain item, leave it blank. If you need more space, please contact the front desk for an extra page or two. An example is provided in the first block for your convenience.* ***Please include in the notes section the effectiveness of the medication, any side effects or reactions your child experienced while taking it, and if you discontinued it, why you did so.***

E X A M P L E

Medication:	Ritalin					**Notes:** Works well to control mood, causes
Rx By:	Dr. Smith			**Dosage:**	50mg	difficulty sleeping at times, weight loss (7 lbs)
Freq:	1 time daily	**Start:**	5/7/2003	**End:**		
For: ADHD						

Note: The 'Start' field pertains to when your child first started taking the medication, and the 'end' field pertains to when he/she stopped taking it. If it is a current medication, leave the 'end' field blank.

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						