

Bismarck Location Minot Location

2625 N 19th Street 2080 36th Ave SW Suite 110

Bismarck, North Dakota 58503 Minot, ND 58701

Phone: 701-222-3175

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[www.reddoorpediatric.com](http://www.reddoorpediatric.com/)

**Counseling Services Intake Form (Adolescent 12-17 yrs.)**

Fill out this form as completely as possible and bring with you the day of the appointment. If you have questions regarding any items, put a checkmark in the left margin and we can discuss them when you come for your appointment.

Today’s date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person completing form (first/last name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are not the individual’s current legal guardian, please list the legal guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type(s) of service desired:

* Individual therapy
* Family therapy

**IDENTIFICATION:**

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_\_

Address of primary residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| *Mother* | *Father* |
| Name: | Name: |
| Age: DOB: | Age: DOB: |
| Cell phone #:  | Cell phone # |
| Home phone # (if different than cell phone #s): |
| Place of Employment: | Place of Employment: |
| Occupation: | Occupation: |
| Work phone #: | Work phone #: |
| Email: | Email: |
| Preferred method of contact (phone call or email):  |
| Emergency contact (name and phone number): |
| Relationship to child: |

Referred by :

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main problem/major reason for seeking help at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had these problems, symptoms, or issues?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had treatment for these issues in the past? { } Yes { } No

* If Yes, where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was it helpful:\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had inpatient mental health treatment? { } Yes { } No

* If Yes, where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician or psychiatrist? { } Yes { } No

* If yes, please provide Doctor’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Condition being treated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications? { } Yes { } No

* If yes, include the following information:

|  |  |  |
| --- | --- | --- |
| Name of medication | Dosage | Prescribing physician |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Do you have a history of trauma/abuse (physical, sexual, emotional, neglect)? { } Yes { } No

* If yes; please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any legal issues at this time? { } Yes { } No

* If yes; please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Difficulties**

Please check all that apply to you:

|  |  |  |
| --- | --- | --- |
| Sadness | X, indicates yes | Please explain: |
| Depression |  |  |
| Loss of enjoyment of usual activities  |  |  |
| Withdrawn  |  |  |
| Irritable  |  |  |
| Angry  |  |  |
| Temper outbursts |  |  |
| Suicidal thoughts/attempts |  |  |
| Self-injury (cutting, ect.) |  |  |
| Trouble going to sleep  |  |  |
| Tiredness/Fatigue |  |  |
| Worry more than others |  |  |
| Fears/Phobias |  |  |
| Panic Attacks  |  |  |
| Nervous/Anxious  |  |  |
| Repeating unnecessary acts over and over (washing hands, turning lights on and off, ect.) |  |  |
| Overly concerned about things  |  |  |
| Having rituals, habits, superstitions, obsessions  |  |  |
| Twitches or unusual movements  |  |  |
| Eating very little/fasting to lose weight |  |  |
| Gorging or binge eating |  |  |
| Poor appetite |  |  |
| Low self-esteem |  |  |
| Conflict with peers  |  |  |
| Conflict with parents/family |  |  |
| Wanting to run away  |  |  |
| Sneaking out at night |  |  |
| Stealing |  |  |
| Lying |  |  |
| Aggression towards people or animals  |  |  |
| Destroying property  |  |  |
| Problems with authority  |  |  |
| Blaming others for your mistakes  |  |  |
| Acting without thinking |  |  |
| Leaving tasks unfinished  |  |  |
| Short attention span  |  |  |
| Easily distracted  |  |  |
| Hallucinations  |  |  |
| Disorientation |  |  |

**Education History**

Current grade level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IEP or 504 plan: { } Yes { } No

Any school difficulties? { } Yes { } No

* If yes, please explain:
	+ Academic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Behavioral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Socially:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you employed? { } Yes { } No

* If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information**

List all of the people who currently live in your household:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Relationship | Occupation/School |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

If child lives between 2 homes, please provide information on the second household below:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Relationship | Occupation/School |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Indicate if you or any family members have currently or have had any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Self | Parent | Sibling | Please explain: |
| Attention, activity or impulse control as a child |  |  |  |  |
| Learning disabilities |  |  |  |  |
| Alcohol abuse/Drug use |  |  |  |  |
| Problems with aggressive behavior as an adult or child |  |  |  |  |
| Antisocial behavior (arrests, jail, legal problems, probation, other) |  |  |  |  |
| Depression |  |  |  |  |
| Anxiety disorders |  |  |  |  |
| Suicidal thoughts/Self-harm behaviors |  |  |  |  |
| Serious illness |  |  |  |  |
| Physical handicaps |  |  |  |  |

What are your supports? (family, friends, extracurricular activities, church, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Stresses**

Please check all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| **Topic** | **Current** | **In the past** | **Please explain:** |
| Parents’ marital problems |  |  |  |
| Parental arguments |  |  |  |
| Parents’ divorce |  |  |  |
| Domestic violence |  |  |  |
| Legal issues |  |  |  |
| Housing/Financial Issues |  |  |  |
| Death of a pet |  |  |  |
| Death of a friend |  |  |  |
| Death of a relative |  |  |  |
| Family illness |  |  |  |
| Family member/close friend using alcohol/drugs |  |  |  |
| Traumatic Events |  |  |  |

If other stressors, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

**PHYSICIAN INFORMATION:**

Primary Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

|  |  |  |
| --- | --- | --- |
| Condition | X, indicates yes | Please explain: |
| Migraines/Headaches |  |  |
| Hormone-related Issues |  |  |
| Head injury |  |  |
| Loss of Consciousness/Dizziness |  |  |
| Allergies |  |  |
| Hospitalizations |  |  |
| Surgeries |  |  |

Do you have any other medical conditions? { } Yes { } No

 If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any goals for Counseling that you would like to work towards: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Counseling Treatment**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent to counseling treatment at Red Door Pediatric Therapy. I give permission for Red Door Pediatric Therapy Counselors to provide treatment which may include assessment advocacy, referral and mental health counseling.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHQ-9 (Depression Inventory)**

Over the last 2 weeks, how often have you been bothered by the following problems? Please circle the number that applies to you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several days | Over half the days | Nearly every day |
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| **Add the score for each column** |  |  |  |  |

**Total Score = \_\_\_\_\_\_\_\_\_**

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?
Not difficult at all \_\_\_\_\_\_\_\_\_\_
Somewhat difficult \_\_\_\_\_\_\_\_\_
Very difficult \_\_\_\_\_\_\_\_\_\_\_\_\_
Extremely difficult \_\_\_\_\_\_\_\_\_

**GAD-7 (Anxiety Inventory)**

Over the last 2 weeks, how often have you been bothered by the following problems? Please circle the number that applies to you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several days | Over half the days | Nearly every day |
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it's hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| **Add the score for each column** |  |  |  |  |

**Total Score = \_\_\_\_\_\_\_\_\_**

If you checked off any problems, how difficult have these made it for you to do your work, take
care of things at home, or get along with other people?
Not difficult at all \_\_\_\_\_\_\_\_\_\_
Somewhat difficult \_\_\_\_\_\_\_\_\_
Very difficult \_\_\_\_\_\_\_\_\_\_\_\_\_
Extremely difficult \_\_\_\_\_\_\_\_\_

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety
disorder. Arch Inern Med. 2006;166:1092-1097.

**Insurance Information**

**Primary coverage:**

|  |  |
| --- | --- |
| Patient name: |  |
| Policyholder: |  |
| Policy ID number: |  |
| Group number: |  |
| Insurance provider number: |  |
| Insurance Company Name:Address:Phone Number: |  |

**Secondary coverage if applicable:**

|  |  |
| --- | --- |
| Patient name: |  |
| Policyholder: |  |
| Policy ID number: |  |
| Group number: |  |
| Insurance provider number: |  |
| Insurance Company Name:Address:Phone Number: |  |

I hereby acknowledge that the information provided above is accurate and current:

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_



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 Attendance Policy

Welcome to Red Door Pediatric Therapy!

Several factors go in to scheduling your child’s evaluations and subsequent appointments including therapy recommendations, insurance approval/parameters, and convenience/availability of preferred times for your family.

Maintaining a consistent therapy schedule is critical to achieve progress toward short and long-term objectives. Because of the demand for therapy services and to ensure positive outcomes on your child’s plan of care, we would like to highlight the following attendance policy:

**Initial Evaluation:**

We understand that conflicts arise, but if you cancel or no show two consecutive initial evaluations, we do not allow you to reschedule an evaluation for a 6-month time frame.

**Permanent Schedule:**

If your child has a time slot on our permanent schedule, those sessions are considered standing appointments. We require a minimum attendance rate of 60% over a 6 month period.

**Call-In Schedule:**

Once you have called in and scheduled your child in an available time slot, those sessions are considered standing appointments. We require a minimum attendance rate of 60% of scheduled appointments. A minimum of 2 sessions per month are required in order to remain on the call-in list.

We understand that sometimes appointments have to be cancelled due to illness, vacation, outside events, and unexpected circumstances. In these instances, we do our best to reschedule to a different time to allow your child to maintain a consistent schedule and receive the recommended number of visits per week.

If we find that you are unable to adhere to our scheduling policy, we will work together to determine the best available schedule that works for your family as well as Red Door Pediatric Therapy. If we are unable to provide consistent therapy services due to lack of attendance, we will discharge your child from therapy for a 6-month time frame. After that, we encourage you to initiate services at a time when attendance and progress toward the plan of care can be a priority.

We appreciate your commitment and can’t wait to get started!