RED DOOR
PEDIATRIC THERAPY

Bismarck Location
2625 N 19th Street
Bismarck, North Dakota 58503

Minot Location
2080 36th Ave SW Suite 110
Minot, ND 58701

Phone: 701-222-3175
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www.reddoorpediatric.com

Counseling Services Intake Form (Adult)

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):_____

Type(s) of service desired:

- Individual therapy
- Couples therapy
- Family therapy

IDENTIFICATION:

Name:	
Gender:	
Date of birth:	
Age:	
Ethnicity:	
Primary address:	
City, State, Zip	
Telephone:	Home: Work: Cell:
Email:	

Referred by :

- _____

Emergency Contact name:	
Emergency Contact number:	
Relationship:	

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

- It yes, where:_____ when:_____ was it helpful:_____

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

- If yes, where:_____ when:_____ was it helpful: _____

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

- If yes, please provide Doctor's name:_____ Phone # _____
  Condition(s) being treated:_____

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

- If yes, include the following information: Name of medications, Dosage, Prescribed by whom

Name of medication	Dosage	Prescribing physician

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

- If yes, please explain: _____

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

- If yes; please explain: _____

Please check all that apply to your current symptoms:

	X, indicates yes	Please explain:
Sadness		

Depression		
Loss of enjoyment of usual activities		
Withdrawn		
Irritable		
Angry		
Suicidal thoughts/attempts		
Self-injury (cutting, ect.)		
Trouble going to sleep		
Tiredness/Fatigue		
Worry more than others		
Fears/Phobias		
Panic Attacks		
Nervous/Anxious		
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 others		
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		

Occupational/Education History

Current employer: _____ Occupation: _____

Highest Level of Education Completed: (please circle)

- Some high school
- High School Diploma/GED
- Some college
- 2 year/4 year college degree; Major: _____ College:_____
- Graduate school/Additional schooling; Major: _____College: _____
- Other: _____

Military Experience: { } Yes { } No

- If yes, Branch: _____ Years of Service: _____

Currently enlisted: { } Yes { } No

Family Information

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

Name	Age	Relationship	Occupation/School

Indicate if there is a family history of the following (immediate or extended family):

	Yes	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)		
Suicide attempts		

Abuse victim		
Depression		
Anxiety		
Other mental health issues		

What are your family supports? (church, friends, clubs etc.): _____

_____

What are your strengths? _____

_____

Additional comments: _____

Family Stresses

Check all that apply:

Topic	**Current**	**In the past**	**Please explain:**
Marital problems			
Parental Arguments			
Marital separation			
Divorce			
Domestic Violence			
Legal issues			
Financial problems			
Job loss			
Custody disputes			
Housing Issues			
Death of a pet			
Death of a friend			
Death of a relative			
Family illness			
Family member/close friend using alcohol/drugs			

Traumatic Events			

Other stressors: If other stressors, please describe: _____

_____

Medical History

PHYSICIAN INFORMATION:

Primary physician:_____

Please mark those that apply to you:

Condition	X, indicates yes	Please explain:
Migraines/Headaches		
High blood pressure		
Hormone-related Issues		
Head injury		
Chronic pain		
Loss of Consciousness/Dizziness		
Heart Attack/Chest Pain		
Seizures		
Kidney-related Issues		
Chronic Fatigue		
Allergies		
Fibromyalgia		
Diabetes		
Hepatitis		
Asthma		
Arthritis		
Thyroid Issues		
HIV/AIDS		
Cancer		

Sexual problems		
Hospitalizations		
Surgeries		

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

- If yes, please describe: _____

Do you have any allergies to medications, drugs or foods? { } Yes { } No

- If yes, please describe:_____

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!