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
Fax: 701-222-3186

Counseling Services Intake Form (Child ages 0-12yrs.)

Our evaluation of your child will depend on information about his/her past history. Fill out this form as completely as possible and bring with you the day of the evaluation. 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 to child:_____

If you are not the child's current legal guardian, please list the legal guardian:_____

Type(s) of service desired:

- Child therapy
- Adolescent therapy
- Family therapy

IDENTIFICATION:

Child's full name: _____Birthdate:_____ Sex: _____ Age: _____

Who does the child live with? _____

Address of child's 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 :

- _____

Please describe the main reason for seeking counseling services: _____

_____

_____

_____

_____

How long has your child had these problems, symptoms, or issues?_____

Has your child had any treatment for these issues in the past? { } Yes { } No

- If yes, was the outcome helpful?_____

If yes, briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome:

_____

_____

Is there any other legal action that may have impacted your child? { } Yes { } No

If yes, please circle and describe all that apply:

- Custody:_____
- Probation: _____
- Visitation: _____
- Adoption: _____
- Child Protective Services: _____

Please check any of the following behaviors that concern you about the child:

Behavior	**Check if yes**	**Please explain:**
Overly active		
Short attention span		
Frequently acts without thinking		
Daydreams/Fantasizes frequently		
Problems with authority		

Stealing		
Temper outbursts		
DIsobedience/Refuses to listen		
Purposely does things that annoy others		
Destroys property		
Irritability		
Anger		
Problems with sleep		
Problems with eating		
Problems with toileting		
Worries more than others		
Panic attacks		
Anxiety		
Has rituals, habits, superstitions, obsessions		
Sadness		
Low motivation		
Low self-esteem		
Expressing a wish to die		
Has threatened/attempted suicide		
Injures self		
Injures others		

Abuse History:

Physical abuse		
Sexual abuse		
Verbal/emotional abuse		
Neglect		

List all of the people who currently live with the child.

Name	Age	Relationship	Occupation/School

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

Name	Age	Relationship	Occupation/School

Do all siblings have the same parents? If no, please explain.

_____

_____

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

	Yes	Please explain:
Attention, activity or impulse control problems as a child		
Learning disabilities		
Alcohol/Drug Abuse		
Problems with aggressive behavior as an adult or child		
Suicide attempts		
Abuse victim		

Depression		
Anxiety		
Other Mental Health Issues		

Please check all that apply to your family:

Topic	**Current**	**In the past**	**Please explain:**
Marital problems			
Marital separation			
Parental arguments			
Domestic violence			
Divorce			
Legal issues			
Financial problems or job loss			
Custody disputes			
Housing Issues			
Death of a pet			
Death of a relative or friend			
Family illness			
Parent(s) using alcohol/drugs			
Involvement of Social Services			
Traumatic Events			

If other stressors, please describe: _____

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

_____

Forms of discipline used in the home: (please circle all that apply and explain)

- Time out: _____
- Loss of privileges: _____
- Grounding: _____
- Rewards/incentives: _____
- Extra chores: _____
- Physical/corporal punishment: _____
- Other: _____

- Please check each item that applies in regard to the child's social development:

Behavior	Current	In the past	Please explain:
Prefers to be alone			
Is demanding and bossy			
Is alone a lot, but dislikes this and feels lonely			
Fights with others			
Is shy			
Bullies others			
Has few friends			
Teases a lot			
Has many friends			
Plays with younger kids			
Plays with "problem kids"			
Plays with older kids			
Is picked on a lot			
Poor relationships with peers			
Is oversensitive			
Conflict with parents/step-parents			
Poor relationships with teachers			
Has difficulty getting along with brothers and sisters			

Your child's school/daycare: _____

Grade: _____Teacher: _____

Is your child currently on an IEP or 504 plan: { } Yes { } No

Please check any area of concern:

Behavior	Current	In the past	Please explain:
Dislikes school			
Missed many school days			
Works hard but does not do well			

Repeated a grade			
Unmotivated			
Refuses to complete work			
Discipline referrals			
Detentions			
Learning problems			
Suspensions, if so how many? _____			
Expulsions, if so how many? _____			

Check all that apply:

Programs	**Current**	**In the past**	**Please explain:**
Resource classes/special ed.			
Continuation school			
Gifted program			
Home study			
Speech therapy			
Occupational therapy			
Independent study			

Other: _____

Child's Primary Doctor:_____

Anything significant to note from pregnancy or delivery (i.e. in utero exposure, medical intervention, etc.? { } Yes { } No

If yes, please explain: _____

_____

Is your child currently taking any medications? { } Yes { } No

- If yes, include the following information: Name of medication, dosage, prescribed by whom

Name of medication	Dosage	Prescribing physician

Indicate if your child has had any of the following:

Condition	**X, indicates yes**	**Please explain:**
Migraines/Headaches		
Hormone-related problems		
Head injuries		
Loss of consciousness/dizzy		
Allergies		
Hospitalizations		
Surgeries		

Does your child have any other medical conditions? { } Yes { } No
If yes, please describe: _____

Does your child frequently complain of bodily aches and pains? { } Yes { } No
If yes, please describe: _____

Does your child miss school because of his/her physical complaints? { } Yes { } No
If yes, please describe: _____

Does your child have any allergies to medications, drugs or foods? { } Yes { } No
If yes, please describe: _____

Do you have concerns with any of the following:

	YES	NO	Please explain:
Communication concerns			
Fine motor concerns			
Gross motor concerns			
Sensory concerns			
Self care completion			
Peer interaction			

Describe your child's strengths and unique qualities:

_____

_____

Goals for child in counseling:

_____

_____

Consent for Child Treatment

I am the legal guardian of _____with full legal authority to consent to treatment. I give permission for Red Door Pediatric Therapy Counselors to provide treatment for this child which may include assessment advocacy, referral and mental health counseling.

Signature: _____Date:_____

Print name:_____Relationship to child:_____

Section 6: 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:	

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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!