Mending Fences Institute
866 Washington Street Canton, MA 02021

Client ____________________
Client # ____________________

Child Intake

Child Name: ________________________________Date of Birth: _________

Gender: ________ Grade _______ School ____________________________

School Phone _________________

Is child on an IEP [ ] Ed plan [ ] Behavior plan [ ] Been expelled Yes [ ] No [ ]

Name of Parent/Guardian completing form: ____________________________

Phone/s: __________________ Email Address: ______________________

Marital Status: ________ Employment Status: _________________________

Home Address: ____

Billing Address if different: ____

List legal Guardians:

____

All parents/guardians consented to treatment Yes[ ] No[ ]

Student Lives With: Both Parents (One Household) [ ] Mother [ ] Father [ ]

Both Parents (Two Households) [ ] Other [ ] ____________________________

Clarify living arrangement and schedule: ______________________________

____

Restraining orders No [ ] Yes [ ] Who ________________________________

In case of Emergency Contact:

Name__________________________________

Relationship ______________ Phone/s: _______________________

Name____________________________

Relationship ____________________ Phone/s: ______________________

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Insurance (bring a copy of your insurance card) Insurance Billing:Yes [ ] No [ ]

Insurance Company ____

Insurance ID: ________________________Group No: ______________________

Subscriber: ________________________________ Date Of Birth: _____________

Social Security #: ______________________ Relationship to Patient: __________

Some insurance companies require authorization prior to the start of treatment. Please call your insurance company, determine if authorization is needed, and request an Outpatient Mental Health Authorization.

Authorization Number: _____________________# Sessions Authorized: ____

Start Date ________________________ End Date _________________________

Medical Information:

Primary Doctor: _______________________________ Email: _______________

Address: _____________________________________Phone: ________________

List Allergies: ____

List Medications: ____

List Conditions: ____

Other Medical Issues and Surgeries: ____________________________________

____

Psychopharmacologist _________________________ Email ________________

Address: _____________________________________ Phone ________________

Additional information

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History and Concerns

(To be filled out by parent/guardian)

History of issues:

Emotional [ ] Learning Disability [ ] Behavior [ ] Trauma[ ]

Does your child exhibit any of the following:

Hyperactivity [ ] Anger [ ] Aggression [ ] Defiance [ ] Sleep problems [ ] Appetite problems [ ] Tantrums [ ] Moodiness [ ]

Anxiety/worries [ ] Repetitive behaviors [ ]

Problems getting along with other children [ ]

Sensory complaint (noise, clothing) [ ]

Frequent headaches or stomach aches [ ]

Developmental History:

Problems during pregnancy/ birth [ ] Developmental delays or problems [ ]

Explain:

Do you have concerns about your child's development (walking, talking etc.)

List your concerns and describe why you are seeking treatment for this child.

What have you done in the past to deal with the issues (include therapists and medications).

List family member and siblings, include ages and with whom they live.

Describe the child's relationship with family members.

What are the child's strengths and interests?

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Goals for Therapy

(To be filled out by Child and Parent individually)

Please describe your perspective of the problem.

Describe your goals for counseling.

What is the most significant challenge to achieving your goals?

What else would you like me to know?

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Agreement

1. I/we have read the Mending Fences Policies and General Information and agree to the terms.
2. If covered by insurance, I/we authorize Beth H Ross LICSW to bill insurance.
3. I/we will each be responsible for the costs not covered by insurance.
4. Bills not paid in full within 30 days will result in a suspension of treatment.
5. I/we have read the electronic communications authorization, understand the risks and authorize communication electronically with me/us, which will include the transmission of my/our PMI electronically.
6. I/we have read the HIPAA confidentiality agreement and understand my rights.
7. I/we give Beth H. Ross LICSW permission to talk with other family members with my/our consent.
8. The above information is true and I/we agree to the consents

Signature: ________________________________ Date ____________

Signature: ________________________________ Date ____________

Signature: ________________________________ Date ____________