Child/Adolescent Intake **Western Reserve Psychological Associates, Inc.**

Date of Initial Visit____________________ **WRPA Therapist**____

Minor's Name ____Birthdate ______________SSN:_________________________
Address____ Phone:______________________
Street City State Zip
Male _____ Female _____
Client Status: Employed _____ Full Time Student _____ Part Time Student _____

School currently attending_______________________________________ Grade________ Religion____________________

Father Name __________________________________ DOB:__________________ SSN:______________________

Address if different from the child____

Home Phone____________________OK to call? Yes _____ No _____ Cell Phone_____________ OK to call? Y_____N_____

Work Phone____________________OK to call? Yes _____ No _____

Employer____
Employment address ____
Street City State Zip

Mother **N**ame _________________________________ DOB:__________________ SSN:______________________

Address if different from the child____

Home phone ___________________ OK to call? Yes _____ No _____ Cell Phone_________________ OK to call? Y_____N_____

Work phone ____________________ OK to call? Yes ____ No _____

Employer ____
Employment address____
Street City State Zip
Names and ages of child's siblings (if applicable): ____
____

Person responsible for deductible, coinsurance, and copayments (This will be the person who brings the child in and also signs the financial responsibility form):____
Address ____
Street City State Zip
Did you contact your insurance company to verify your benefits and let them know you were coming? ________
Deductible/year $_________ Has it been met?_______ Copayment/coinsurance/visit $_______ or _____%
Did you receive an authorization number from your insurance company? Yes_____ No_____
Authorization number ____ Number of visits ______
Did you get a referral from your Primary Care Physician if required by your ins. co.? Yes_____ No_____

Insurance Information		For Secondary Ins. Only	
Policy Holder's ID/SS#	____________________	Policy Holder's ID/SS#	____________________
Ins Co. Name	____________________	Ins. Co. Name	____________________
Policy Holder's Name	____________________	Policy Holder's Name	____________________
Relationship to client	____________________	Relationship to client	____________________
Policy Holder's Address	____________________	Policy Holder's Address	____________________
	____________________		____________________
Policy/Group #	____________________	Policy/Group #	____________________
Policy Holder's DOB	____________________	Policy Holder's DOB	____________________
Male _____ Female _____		Male _____Female _____	
Employer	____________________	Employer	____________________

How did you hear about our practice? ____
When you decided to call us, where did you get our phone number?______________________________________

May we thank your referral source? Yes _____ No____ If yes, referral address____________________________
Did you search for more information about us on the internet? _______
Did you use a search engine? Yahoo _____, Google _____, AltaVista _____, Other ______________________
Did you visit our website? _______ For what purpose? ____

Client Name____ Date_________________________

Have you received mental health care previously? Yes _____ No_____
If so, name of therapist or group? ____
When? ____
What issues were addressed?
____
____

In your own words, what issues bring you here at this time?
____
____

Describe academic functioning (learning problems): ____
____

Describe any major medical/physical problems:
____
____

List known allergies:
____
____

Primary Care Physician____ Phone: _______________________
Address ____
Date of last visit __________________

List current medications prescribed by this doctor:

Medication	Daily Dose	Condition	Starting Date

Psychiatrist, if applicable _____________________________________ Phone: _________________________
Address ____
Date of last visit __________________

List current medications prescribed by this doctor:

Medication	Daily Dose	Condition	Starting Date

Nearest relative or friend (not spouse) we may contact in case of emergency:

Name Relationship Phone