*Revised July 2020*

**TAMU Psychology Clinic—Child or Adolescent—Intake Information**

**PART 1: TAMU Psychology Clinic Phone Intake Information (previously provided by phone)**

**PART 2: Please provide the following additional information**

**Date*:***Click or tap here to enter text. **Child’s Name:**Click or tap here to enter text.

**Child’s Age:**Click or tap here to enter text. **Child’s Gender**:  Female  Male

**Child’s Date of birth**: Click or tap here to enter text.*month* Click or tap here to enter text.*day* Click or tap here to enter text. *year*

**Child’s Race/Ethnic Origin** (*select all that apply*)

Anglo American/White  Latinx/Hispanic  African American/Black  Asian American/Asian  Native Hawaiian/Other Pacific Islander  Native American/Alaska Native  Middle Eastern/North African  Other:Click or tap here to enter text.  Prefer not to say

**Child’s Family Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Relation to Child | Age | Highest Education Completed | Employment Status | Emotional or Learning Difficulties (Y/N) |
|  | Choose an item. |  | Choose an item. | Choose an item. |  |
|  | Choose an item. |  | Choose an item. | Choose an item. |  |
|  | Choose an item. |  | Choose an item. | Choose an item. |  |
|  | Choose an item. |  | Choose an item. | Choose an item. |  |
|  | Choose an item. |  | Choose an item. | Choose an item. |  |
|  | Choose an item. |  | Choose an item. | Choose an item. |  |
|  | Choose an item. |  | Choose an item. | Choose an item. |  |

**Parents’ Marital Status**

Single, never married  Married or domestic partnership  Widowed  Divorced  Separated

Current or pending involvement with?  courts  mediation

If separated or divorced, what are the current custody arrangements for child(ren)?Click or tap here to enter text.

**Child’s Medical Information**

Current state of health:  Poor  Somewhat Poor  Well  Somewhat Well  Very Well

Primary Care Physician (name; phone number): Click or tap here to enter text.

Currently using medications for behavior/emotions/thought processes?  No  Yes; Describe below:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose | Reason/Purpose | Prescribing Physician |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Name/Phone to contact in case of an emergency:Click or tap here to enter text.

**Areas of Concern** Do you or have you had any difficulties with the following *(present = within previous month)*:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Past** | **Present** |  | **Past** | **Present** |
| Growth/Development |  |  | Hyper-Activity |  |  |
| School/Learning |  |  | Disruptive/Disobedient Behavior |  |  |
| School/Behavior |  |  | Self-Confidence |  |  |
| Language/Speech |  |  | Loneliness |  |  |
| Depression |  |  | Relationship w/ parents |  |  |
| Anxiety |  |  | Relationship w/ siblings |  |  |
| Moodiness |  |  | Relationship w/ extended family |  |  |
| Anger |  |  | Relationship w/ friends |  |  |
| Eating |  |  | Inattention/poor concentration |  |  |
| Sleeping |  |  | Identity Issues |  |  |
| Headaches/Pain |  |  | Suicidal Thoughts/Actions |  |  |
| Dizziness/Fainting |  |  | Self-Harm Thoughts/Actions |  |  |
| Stomach/Digestion |  |  | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Alcohol/Substance Misuse |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Stress |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

What are your child’s strengths?Click or tap here to enter text.

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*Based on information you provided, your fee has been set at: \_\_\_\_\_\_\_ per 50- to 60-min. therapy appt.*

*\_\_\_\_\_\_\_ per hour for evaluation services*

*Full payment for services is due at the start of all in-person appointments. Payment by check, money order, cashier’s check, or bank bill-pay service must be received my postal mail to the Clinic for all tele-behavioral health services. To be able to make & attend the next scheduled appointment, clients must have a paid account or carry an account balance no more than three times(3x) the appointment/hour rate. To receive a printed copy of your evaluation report, all fees must be paid. All Clinic fees are self-pay. Health insurance entities do not accept our therapists/evaluators as payable providers****.***

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**Future Record Request Verification Form**

*Please thoroughly provide or confirm all information below. This information will be used to verify your identity if you request Clinic records in the future. Client identity information is stored securely and protected from disclosure in accordance with Federal and State laws.*

*For office use: Client Record Number*

**Child’s Full Legal Name**:Click or tap here to enter text.

Last First Middle Suffix

**Child’s Last 4 digits SSN**Click or tap here to enter text. **Current Age**:Click or tap here to enter text. years

**Date of Birth****:**Click or tap here to enter text.

**Services Received from TAMU Psychology Clinic**

Testing/Evaluation services  Therapy services  Other Click or tap here to enter text.

**Start Date of Services****:**\_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ **End Date of Services:**\_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

month / day /19xx or 20xx month / day /19xx or 20xx

***added later by Clinic office***

**Parent(s) or Guardian(s) Full Legal Name(s):**

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

Last First Middle Suffix

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

Last First Middle Suffix

**Name of first elementary school your child attended**Click or tap here to enter text.

**Name of city in which your child was born**:Click or tap here to enter text.