

# Mequon Clinical Associates, SC

## CHILD / ADOLESCENT HISTORY

INSTRUCTIONS: Therapist would like parents / guardian answers to these questions to help better understand your child's situation.

Child's Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Preferred Name (if applicable): \_\_\_\_\_ Gender: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

In case of emergency, please give name and phone number of child's parent or legal guardian:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's School: \_\_\_\_\_ Phone: \_\_\_\_\_

School Contact (counselor/teacher, etc.): \_\_\_\_\_ Phone: \_\_\_\_\_

### PSYCHOLOGICAL HISTORY

What problem(s) caused you to come to therapy?

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

Have there been any recent illnesses or deaths among your child's family or close friends?  Yes  No

Have there been any recent crises or major changes for your family?  Yes  No

Any history of emotional, physical, or sexual abuse in the family?  Yes  No

Has your child ever intentionally hurt himself/herself or made a suicide attempt?  Yes  No

Has your child ever intentionally hurt others?  Yes  No

Has your child ever run away?  Yes  No

Is your child or any family member taking any medication for anxiety, depression, sleep, or other behavioral health issues?  Yes  No

Is there a family history of emotional problems?  Yes  No

Have you or your child ever been in counseling or psychotherapy before?  Yes  No

If yes, for what issues? \_\_\_\_\_

Who did you see and when? \_\_\_\_\_

Any hospitalizations in the family for emotional problems?  Yes  No

Please name any people or organizations that provide help and support to your family: \_\_\_\_\_

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

### MEDICAL HISTORY

List your child's current medical conditions: \_\_\_\_\_

Are any medications taken for these conditions?  Yes  No

If yes, what medications and dosages? \_\_\_\_\_

List other major medical conditions your child had in the past (including surgeries): \_\_\_\_\_

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

Name of child's physician(s), telephone number(s) and address(es): \_\_\_\_\_

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

When was child's last medical exam? \_\_\_\_\_

Describe other significant medical conditions in your family, including inherited disease or disabilities: \_\_\_\_\_

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

**Check any of these symptoms your child experienced in the past year:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> School problems           | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Crying spells           |
| <input type="checkbox"/> Learning disability       | <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Eating changes/problems |
| <input type="checkbox"/> Developmental delays      | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Sleep changes/problems  |
| <input type="checkbox"/> Speech problems           | <input type="checkbox"/> Stomach problems          | <input type="checkbox"/> Refuses to obey         |
| <input type="checkbox"/> Hyperactivity             | <input type="checkbox"/> Low energy/fatigue        | <input type="checkbox"/> Nervousness             |
| <input type="checkbox"/> Short attention span      | <input type="checkbox"/> Bedwetting or soiling     | <input type="checkbox"/> Nightmares              |
| <input type="checkbox"/> Gender identity questions | <input type="checkbox"/> Sexual identity questions |  |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Other _____               |  |

**DRUG AND ALCOHOL USE**

**Please describe the drug and alcohol use of your family. Use the number which best states how often each person uses each drug. For siblings, please write in the name of sibling at the top of the column.**

*0 = Never; 1 = less than once a month; 2= 1-4 days a month; 3 = almost daily; 4 = daily; 5 = used in past, not using now*

<b>SUBSTANCE</b>	<b>CHILD</b>	<b>MOTHER</b>	<b>FATHER</b>	<b>SIBLING</b>
Nicotine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
LSD	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____
Other	_____	_____	_____	_____

**LEGAL PROBLEMS**

**Has your child ever had problems with law enforcement?**  Yes  No

If yes, provide context: \_\_\_\_\_

**Has your child ever been involved with Protective Services?**  Yes  No

If yes, provider context: \_\_\_\_\_

**SCHOOL HISTORY**

**Where does your child currently enrolled in school?** \_\_\_\_\_

**Does your child have a problem with school attendance?**  Yes  No

**Does your child have a problem with school behavior?**  Yes  No

**Does your child have a problem with learning or academic performance?**  Yes  No

**Child's highest grade completed:** \_\_\_\_\_

**Mequon Clinical Associates, SC**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
Please print

**Other Adult:** \_\_\_\_\_ **Relation to patient:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

\_\_\_\_\_ **Email:** \_\_\_\_\_

\_\_\_\_\_ **Referred by:** \_\_\_\_\_

**Reminder Preference (please check only one box):**

- Phone Call (Home #)       Phone Call (Cell #)       Text Message

**FINANCIAL POLICY**

Payment is expected at the time of service. You are ultimately financially responsible for all services you or members of your household receive from Mequon Clinical Associates.

**Consent to Treatment/Privacy Policy**

I hereby consent to treatment as agreed upon by my MCA Provider and myself, and I understand my rights as a patient. I have received and understand the written Notice of Privacy Practices provided by Mequon Clinical Associates.

\_\_\_\_\_ initials

**Private Pay**

If you will be paying for visits privately (i.e., not through an insurance company), clinic policy requires payment at time of service. Please be prepared to make payment upon arrival for your session.

\_\_\_\_\_ initials

**Health Insurance**

I authorize insurance payment of medical benefits to Mequon Clinical Associates for services described on the itemized claim form. I also authorize the release of information necessary to process this claim. Payment of benefits should be paid directly to Mequon Clinical Associates. **I recognize and accept personal responsibility for all services rendered and will make payment in full of any self-pay charges, co-payments or deductibles, and for any balance outstanding after payment or denial of such insurance benefits.**

**Client / Financially Responsible Party Signature:** \_\_\_\_\_

**Outstanding Patient Balances**

After insurance is billed any portion not covered will be billed to the patient. Any balance that is billed to the patient must be paid in full no later than 60 days from the billing date. The clinic charges a \$30 fee to you for any returned checks, which is payable before or at the time of your next scheduled visit.

\_\_\_\_\_ initials

**Cancelled Appointments**

I understand that any appointments cancelled or missed without 24 hours notice may be charged a minimum fee of \$75 and **my insurance does not cover this fee.**

\_\_\_\_\_ initials

**Failure and/or Inability to Pay**

In the event it becomes necessary to assign your account to a collection agency, you are responsible for any/all costs of collection which may include attorney fees and other costs incurred.

\_\_\_\_\_ initials

**I have read and understand the above financial policy.**

**Client / Financially Responsible Party Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Please Print Name:** \_\_\_\_\_