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:

____ School problems	____ Headaches	____ Crying spells
____ Learning disability	____ Anemia	____ Eating changes/problems
____ Developmental delays	____ Diabetes	____ Sleep changes/problems
____ Speech problems	____ Stomach problems	____ Refuses to obey
____ Hyperactivity	____ Low energy/fatigue	____ Nervousness
____ Short attention span	____ Bedwetting or soiling	____ Nightmares
____ Gender identity questions	____ Sexual identity questions	
____ Asthma	____ 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

SUBSTANCE	CHILD	MOTHER	FATHER		SIBLING
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: _____

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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 or your insurance is a Medicaid policy), clinic policy requires payment at time of service. Please be prepared to make payment upon arrival for your session.

_____initials

Health Insurance
I have been advised that Mequon Clinical Associates does not accept any Medicaid insurance (which includes HMO Medicaid and Badgercare policies) and that I will be financially responsible if I have or obtain a Medicaid policy in the future.

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.**

_____initials

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. If you are 15 or more minutes late for your appointment, it will be at the providers discretion to charge 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:** _____