Heartland Psychological Services

A South Dakota Nonprofit Corporation - Client Information Questionnaire

Child and Adolescent Form

Welcome! Please fill out this questionnaire, as it will be useful in getting to know you, your child, and help us plan our services for you. Please fill in all pages as completely as possible. If an item is unclear, feel free to ask your therapist for clarification. We are so glad you are here and look forward to working with you.

General Client Information

_____

Legal First Name **M.I.** **Legal Last Name**

What name do you prefer we call you? _____ **Preferred Pronouns:**_____

Address: _____

City: _____**State:** _____ **Zip:** _____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:** _____

Email: _____

Date of Birth (mm/dd/yyyy): _____**Age:** _____ **Preferred Gender:** _____

Race/Ethnicity: _____**Is Spirituality or Religion important to you?** ☐

School: _____ **Grade:** _____

Current or Last Teacher: _____

Were you referred by a healthcare professional? ☐ If yes, which one? _____

May your therapist contact them? ☐ Yes ☐ No

Siblings (if applicable):

Legal Name	**Date of Birth**	**Age**	**Full/Half/Step/Foster**

Parent/Caregiver/Guardian Information

Parent/Caregiver/Guardian:

_____

Legal First Name **M.I.** **Legal Last Name**

Preferred Name: _____**Preferred Pronouns:** _____

Address: _____

City: _____**State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email: _____

*Please check the boxes to indicate **Yes**:*

May we call Home? ☐ **May we leave a message at Home?** ☐ **Would you like to receive appointment**
Work? ☐ **Cell?** ☐ **Work?** ☐ **Cell?** ☐ **reminders via text message?** ☐

Date of Birth (mm/dd/yyyy): _____**Age:** _____ **Preferred Gender:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** **Date:** _____

Race/Ethnicity: _____**Is Spirituality or Religion important to you?** ☐

Veteran: ☐ **Active Duty** ☐ Dates of Service:_____

Employment: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Homemaker ☐ Student
☐ Retired ☐ Disabled ☐ Unemployed ☐ Other _____

Employer (if applicable): _____ **Length of Employment:** _____

Parent/Caregiver/Guardian:

_____

Legal First Name **M.I.** **Legal Last Name**

Preferred Name: _____**Preferred Pronouns:** _____

Address (if different than above):_____

City: _____**State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email: _____

*Please check the boxes to indicate **Yes**:*

May we call Home? ☐ **May we leave a message at Home?** ☐ **Would you like to receive appointment**
Work? ☐ **Cell?** ☐ **Work?** ☐ **Cell?** ☐ **reminders via text message?** ☐

Date of Birth (mm/dd/yyyy): _____**Age:** _____ **Preferred Gender:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** Date: _____

Race/Ethnicity: _____ **Is Spirituality or Religion important to you?** ☐

Veteran: ☐ **Active Duty** ☐ Dates of Service: _____

Employment: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Homemaker ☐ Student
☐ **Retired** ☐ **Disabled** ☐ **Unemployed** ☐ **Other** _____

Employer (if applicable): _____ **Length of Employment:** _____

Symptom Screening Checklist

Please rate any of the following symptoms that you notice your child experiencing currently or have experienced in the past and list the duration of the symptom.

Symptom	Frequency			Duration
	Never	Often	Always	
Depression	☐	☐	☐	_____
Unhappiness	☐	☐	☐	_____
Suicidal Thoughts	☐	☐	☐	_____
Self-Harm	☐	☐	☐	_____
Nervousness	☐	☐	☐	_____
Fears	☐	☐	☐	_____
Shyness	☐	☐	☐	_____
Education/School	☐	☐	☐	_____
Friends/Peers	☐	☐	☐	_____
Sibling Conflict	☐	☐	☐	_____
Loss of Relationship	☐	☐	☐	_____
Alcohol Use	☐	☐	☐	_____
Drug Use	☐	☐	☐	_____
Excessive Worry	☐	☐	☐	_____
Lying	☐	☐	☐	_____
Stress	☐	☐	☐	_____
Energy Level	☐	☐	☐	_____
Loneliness	☐	☐	☐	_____
Tiredness	☐	☐	☐	_____
Gender/Sexual Issues	☐	☐	☐	_____
Low Self-Esteem	☐	☐	☐	_____
Ambition	☐	☐	☐	_____
Making Decisions	☐	☐	☐	_____
Self-Control	☐	☐	☐	_____
Hyperactivity	☐	☐	☐	_____
Repetitive Behaviors	☐	☐	☐	_____
Anger	☐	☐	☐	_____
Fire-Setting	☐	☐	☐	_____
Sleep Difficulties	☐	☐	☐	_____
Nightmares	☐	☐	☐	_____

Symptom	Frequency			Duration
	Never	Often	Always	
Bedwetting	☐	☐	☐	_____
Verbal Aggression	☐	☐	☐	_____
Physical Aggression	☐	☐	☐	_____
Disrespectful/Defiant	☐	☐	☐	_____
Conflict with Parents	☐	☐	☐	_____
Runs Away from Home	☐	☐	☐	_____
Temper	☐	☐	☐	_____
Memory	☐	☐	☐	_____
Concentration	☐	☐	☐	_____
Relaxation	☐	☐	☐	_____
Appetite	☐	☐	☐	_____
Parental Separation	☐	☐	☐	_____
Parental Marriage	☐	☐	☐	_____
Parental Divorce	☐	☐	☐	_____
Health Problems	☐	☐	☐	_____
Headaches	☐	☐	☐	_____
Bowel Troubles	☐	☐	☐	_____
Stomach Troubles	☐	☐	☐	_____
Career Choices	☐	☐	☐	_____
Work Problems	☐	☐	☐	_____
Internet	☐	☐	☐	_____
Computer Games	☐	☐	☐	_____
Pornography	☐	☐	☐	_____
Food Binging	☐	☐	☐	_____
Food Purging	☐	☐	☐	_____
Food Restricting	☐	☐	☐	_____
Exercise	☐	☐	☐	_____
Bullied by Others	☐	☐	☐	_____
Bullying Others	☐	☐	☐	_____
Grief	☐	☐	☐	_____

My Appetite: ☐ Normal ☐ Less than usual ☐ Much less than usual ☐ No appetite at all ☐ More than usual ☐ Much more than usual ☐ Crave food all the time

My Sleep Pattern: ☐ Normal ☐ Difficulty falling asleep ☐ Excessive sleep ☐ Diminished sleep ☐ Frequent awakening ☐ Nightmares ☐ Sleepwalking ☐ Early morning awakening

Have the above symptoms ever caused concerns for your child in any of the following areas: Personally☐ Socially ☐ Occupationally☐ Academically☐ If yes, please explain: _____

_____

_____

Please describe recent stressors in your environment (e.g., moves or relocations, losses, changes in custody, environment, or school): _____

_____

Client History

Academic History

*Please check the boxes to indicate **Yes:***

Highest level of education: _____ Grade: _____
Has your child had any difficulty with: ☐ Grades ☐ School Progress ☐ School Behaviors ☐ School Peers
If so, please describe: _____
_____

Has your child been placed on or completed any of the following? ☐ School Intervention ☐ IEP
☐ 504 ☐ Special Education Plan ☐ Learning Disability Accommodations
If so, please describe: _____
_____

Please describe any jobs or training your child has received:

_____
_____

Legal History

*Please check the boxes to indicate **Yes**:*

Has anyone committed a crime against your child? ☐ If so, what was the crime and its current legal status:

_____
_____

Has your child ever committed a crime? ☐ **Has your child been placed on:** Probation ☐ Parole ☐
Has your child ever been placed in a correctional facility? ☐ Time Served: _____
If yes to any of the above, please describe: _____
Has your child ever: Destroyed Property ☐ Shown Violence or Assault Towards Others ☐
If yes to any of the above, please describe: _____
_____

Abuse History

*Please check the boxes to indicate **Yes**:*

Has your child ever experienced abused? Physically ☐ Emotionally ☐ Sexually ☐ Mentally ☐
If yes, please describe: _____
_____
_____

Has your child ever experienced bullying? ☐ If yes, please describe: _____
_____
_____

Family & Psychiatric History

Please list any other family members or individuals that reside in the same household as you (if different from previously stated):

_____

_____

Please describe any recent family stressors and/or changes (e.g., illness, deaths, separations, incarceration, loss of job, moves, changes in custody, changes in schools, etc.):

_____

_____

Please describe strengths and weaknesses in the relationships between family members:

_____

_____

Has your child ever received counseling or psychiatric treatment before? Yes☐ No☐
If yes, please describe: _____

_____

What was liked/disliked while receiving previous treatment? _____

_____

Please list any Psychiatric Hospitalizations:

Year	Hospital	Purpose of Hospitalization	Admitting Physician	Length of Stay

Please indicate any family history of Psychological Problems:

Name	Relationship to Your Child	What was the Problem?	Treatment Given

Developmental History

Please describe any difficulties or complications with the pregnancy or birth of your child: _____

_____

Did your child meet general milestones on time, such as walking and talking? ☐ Yes ☐ No
If no, please describe: _____

_____

Please describe any prenatal concerns in use of alcohol or drugs during pregnancy: _____

_____

Please describe any difficulties with physical development in your child: _____

_____

_____

Medical History

Primary Physician: _____Phone Number: _____
Clinic Name & Location: _____
Last Exam: _____
Reason for visit? _____
_____

Please list any major health problems for which you have or are currently receiving treatment:

_____
_____
_____
_____

Please list chronologically all medication (from oldest to most recent) that your child has used in the *past year*:

Medication	Purpose of Medication	Prescribing Physician	Date Started	Date Stopped

Please list any known allergies to medication, food, or products: _____
_____
_____

Please list any Medical Hospitalizations or Treatment:

Date	Hospital	Purpose for Hospitalization	Admitting Physician	Length of Stay

Social History

What leisure activities or hobbies does your child enjoy? _____

_____

_____

_____

Does your child prefer to do activities alone or with others? Alone ☐ With Others ☐ Both ☐

How many friends does your child have? Few ☐ Several ☐ Many ☐

What clubs, organizations, or social activities does your child participate in on a regular basis?

Please list if applicable: _____

_____

_____

Does your child have a job? ☐ If so, please describe: _____

Alcohol/Drug Use/Other Addictive Behavior Profile:

*Please check the boxes to indicate **Yes:***

Have the following behaviors ever caused problems for your child?

Alcohol ☐ Frequency_____

Drugs/Substances ☐ Frequency_____

Medications ☐ Frequency_____

Gambling ☐ Frequency_____

Eating ☐ Frequency_____

Sex ☐ Frequency_____

Internet/Computer Usage ☐ Frequency_____

Smoking ☐ Frequency_____

Other ☐ Frequency_____

If answered yes to any listed above, please explain: _____

_____

_____

Have the above behaviors caused concerns in any of the following areas: Personally ☐ Socially ☐
Occupationally ☐ Academically ☐ If yes, please explain: _____

_____

Has your child ever received treatment for alcohol/other drug misuse/other addictive behaviors (i.e., gambling, sex, internet, eating, smoking, etc.)? Yes ☐ No ☐ If yes, please complete the following:

Year	Place	Length of Stay/Number of Sessions	Did your child complete the program?

_____

_____

Please indicate any family history of addictive behaviors (alcohol, drugs, prescription or over-the-counter medications, gambling, smoking, eating disorders, etc.):_____

_____

Client Assets

Please check and list the strengths that your child holds:

- ☐ Good communication skills
- ☐ Intelligent
- ☐ Assertive
- ☐ Confident
- ☐ Motivated
- ☐ Medication compliant
- ☐ Coordinated
- ☐ Other _____

- ☐ Healthy
- ☐ Outgoing
- ☐ Careful, good judgment
- ☐ Mature
- ☐ Good support system
- ☐ Self-sufficient
- ☐ Friendly
- ☐ Other _____

- ☐ Creative
- ☐ Optimistic
- ☐ Good knowledge of parenting
- ☐ Expresses feelings well
- ☐ Healthy friends and relationships
- ☐ Expresses thoughts well
- ☐ Reliable
- ☐ Other _____

Client Limitations

Please check the weaknesses or limitations your child has dealt with:

- ☐ Low self-esteem
- ☐ Dependent
- ☐ Insecure
- ☐ Impulsive
- ☐ Struggle to following directions
- ☐ Pessimistic

- ☐ Difficulty with judgment
- ☐ Problems with anger management
- ☐ Trouble communicating
- ☐ Difficulty making friends
- ☐ Difficulty with emotional controls
- ☐ Other _____

- ☐ Need help with social skills
- ☐ Poor Memory
- ☐ Anxious
- ☐ Lack of motivation
- ☐ Impatient
- ☐ Other _____

What brings your child to Heartland at this time? _____

_____

Personal goals you or your child has for treatment: _____

_____

Please share any additional information that you feel would be helpful for your therapist to know to best help your child: _____

_____

The Mission of Heartland

To help people in distress relieve their suffering, restore their hope, and reach their potential in an environment of encouragement, compassion, and respect with highly qualified staff committed to effective services.

Heartland Psychological Services

Insurance Information

Primary Coverage:

NAME OF INSURANCE COMPANY POLICY HOLDER'S NAME INSURANCE PHONE NUMBER

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ID #: _____POLICY #: _____GROUP #: _____

Supplemental Coverage:

NAME OF INSURANCE COMPANY POLICY HOLDER'S NAME INSURANCE PHONE NUMBER

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ID #: _____POLICY #: _____GROUP #: _____

INSURANCE SIGNATURE AUTHORIZATION

TO PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER:

I, _____ authorize the release to my insurance company of medical information or other information necessary to process claims, determine benefits, or respond to my insurance company's audit of records. I also request that payment of authorized insurance benefits be made on my behalf to Heartland Psychological Services for any services furnished me by Heartland Psychological Services employees.

NOTE: If I am a SD Medicaid recipient, I understand that it is my responsibility to provide a referral card according to the Managed Card instructions. If I am a SD Medicaid recipient, I will allow the South Dakota Medicaid Program, Medical Services, to access any and all material which may be deemed confidential by any regulatory or licensing agency, board or commission as required by Title XIX. If I am a NE Medicaid recipient, I will allow the Nebraska Medicaid Program and Magellan Behavioral Health to access any and all material which may be deemed confidential by any regulatory or licensing agency, board or commission as required by Nebraska Medicaid or Magellan Behavioral Health.

FOR YOUR INFORMATION: In certain cases, some therapy services are not covered by insurance, i.e., marital therapy, collateral therapy. We will be glad to assist you in checking on coverage for your therapy. Please let us know if you want help with this. **Also please note:** If you have more than one insurance carrier, it is extremely important that you provide the correct information to us regarding which insurance is primary. If Heartland is required to reimburse an insurance company because of an error regarding primary coverage or change in insurance coverage, you may be asked to reimburse Heartland for such payments.

Signature _____ Date _____
(If minor, signature of parent or guardian)

Witness Signature _____ Date _____