Cristina Mantilla, LMHC, LLC. 5745 Main St Suite 202 New Port Richey, FL 34652
1501 S. Pinellas Ave. Suite K Tarpon Springs, FL 34689 Office 727-505-6379 / Fax 1-866-926-7270

ADOLESCENT / CHILD INTAKE EVALUATION

Date: _____Name: _____
Bio Mother's Name: _____
Bio Father's Name: _____
Gaurdian/Step-parent's Name: _____
Guardian/Step-Parent's Name: _____
Street: _____Apt/Bldg: _____
City: _____State: _____ Zip: _____
Parent Cell Phone: _____OK to leave message? _____
Adolescent Cell Phone: _____OK to leave message?_____
Home Phone: _____OK to leave message? _____
Work Phone: _____ OK to leave a message? _____
E-mail: _____DOB: _____Age:_____
Social Security Number: _____ Race: _____
Adolescent's Driver's License Number: _____
Emergency Contact (Name/Number): _____

Emergency Contact (Name/Number):_____

PCP: _____Telephone Number:_____

Other Current Medical Professionals (Psychiatrists, Psychologists, Counselors, Support Groups, etc.): Telephone Number:

_____ _____

_____ _____

_____ _____

Referral Source: _____

RELEASE OF INFORMATION:
IN ORDER TO PROCESS MY CLAIM, I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY FOR THIS PURPOSE ONLY.
I hereby assign all medical, including Major Medical benefits to which I am entitled, to the above named PROVIDER.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
THERAPIST SIGNATURE DATE

I appreciate the opportunity to help enhance the quality of your life.

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INSURANCE INFORMATION:

IS SCHOOL BOARD PAYING? ___YES ___NO DO YOU HAVE PRIVATE INSURANCE? ___YES ___NO

IS THE CLIENT A MINOR? ___YES ___NO

DO YOU HAVE MEDICAID? ___YES ___NO DO YOU HAVE MEDICARE ?___YES ___NO

IF YES, PLEASE COMPLETE SECONDARY INSURANCE INFORMATION.

PRIMARY INSURANCE:

PRIMARY INSURED NAME:_____ DOB:_____ SEX:_____

SS# OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____ INSURANCE CO:_____

ADDRESS:_____

GROUP #:_____ POLICY #:_____

SECONDARY INSURANCE (IF APPLICABLE):

INSURED NAME:_____ DOB:_____ SEX:_____

SS# OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____ INSURANCE CO:_____

ADDRESS:_____ GROUP #:_____

POLICY #:_____

ALL APPOINTMENTS MUST BE CHANGED OR CANCELLED 24 HOURS IN ADVANCE TO AVOID A $40.00CHARGE.

"I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I WILL NOTIFY YOU OF ANY CHANGES TO THIS INFORMATION. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE."

_____ _____

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CLIENT INFORMATION:

SCHOOL:_____ GRADE:_____ SPECIAL CLASSES:_____

TEACHER:_____

REFERRED BY:_____

PRESENTING PROBLEMS AND HISTORY OF PROBLEMS: (HOME)

_____

_____

SCHOOL HISTORY:

CHILD'S REACTION TO STARTING SCHOOL, CURRENT ATTITUDE TO SCHOOL. ANY GRADES SKIPPED OR REPEATED, CURRENT ACADEMICS GRADE, ANY SCHOOL BEHAVIOR

PROBLEMS:_____

_____

_____

PRIOR TREATMENT:

PLACE/PERSON/AGENCY DATE OUTCOME

_____

_____

MEDICATIONS:

Rx	Prescribed By	For	Dose	Times Taken per day	Outcome

ANY PAST MEDICATION FOR PSYCHIATRIC PURPOSES:_____

POTENTIAL FOR DANGEROUSNESS TO SELF: LOW _____ MODERATE _____ HIGH _____

POTENTIAL FOR DANGEROUSNESS TO OTHERS: LOW _____ MODERATE _____ HIGH _____

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HAS CHILD EXPERIENCED ANY OF THE FOLLOWING, INDICATE CHILD'S AGE AT TIME:

DEATH OF A SIGNIFICANT PERSON: (WHOM) CHILDS AGE

_____ _____

_____ _____

SEPARATION FROM A FAMILY MEMBER: (WHOM) CHILDS AGE

_____ _____

_____ _____

HAS CHILD EXPERIENCED ANY OF THE FOLLOWING, INDICATE CHILD'S AGE AT TIME:

PHYSICAL ABUSE: (BY WHOM) CHILDS AGE

_____ _____

_____ _____

SEXUAL ABUSE: (BY WHOM) CHILDS AGE

_____ _____

_____ _____

FAMILY PROBLEMS: (CHECK WHICH ONES APPLY)

_____ LEGAL PROBLEMS _____ MARITAL PROBLEMS

_____ FINANCIAL DIFFICULTIES _____ OTHER

EXPLAIN:_____

_____

ADDITIONAL FAMILY HISTORY:

_____

_____

_____

PRENATAL INFORMATION:

COMPLICATIONS DURING PREGNANCY? _____

_____

DRUG/ALCOHOL/PRESCRIPTION MEDICATION DURING PREGNANCY? _____

_____

DELIVERY:

FULL TERM? YES____ NO____IF NOT, # OF WEEKS PREMATURE_____

VAGINAL? _____ C-SECTION?____

ANY MEDICAL DIFFICULTIES DURING OR AT BIRTH?_____

DEVELOPMENTAL HISTORY: (CHECK WHICH ITEMS WERE DIFFICULT FOR YOUR CHILD)

RESPONDS TO SIGNIFICANT OTHERS:_____ SPEAKING WORDS: _____

SITTING UP:____ TALKING IN SENTENCES: ____

WALKING:_____ TOILET TRAINED: _____

SEPARATION FROM PARENTS TO GO TO SCHOOL: _____

I appreciate the opportunity to help enhance the quality of your life.

MEDICAL HISTORY

ANY SIGNIFICANT ILLNESSES, ACCIDENTS AND/OR HOSPITALIZATIONS, INCLUDE AGES

_____

_____

APPETITE: GOOD: _____ FAIR: _____ POOR: _____ UP AND DOWN: _____

SLEEP DISTURBANCE: (CHECK WHICH ONES APPLY TO YOUR CHILD)

_____ PROBLEM GETTING TO SLEEP _____ WAKING EARLY

_____ PROBLEM STAYING ASLEEP _____ SLEEPS MORE THAN 8-10 HOURS

_____ PROBLEM GETTING UP _____ SLEEPS LESS THAN 6-8 HOURS

BLADDER/BOWEL DIFFICULTIES: _____

LEGAL:

HAS YOUR CHILD HAD LEGAL PROBLEMS? IF YES, EXPLAIN:_____

_____

SCHOOL REFERRALS FOR MISBEHAVIOR?: _____

DRUG/ALCOHOL/TOBACCO HISTORY:

CHILD:_____

PARENTS:_____

INTEREST AND ACTIVITIES: _____

_____

CHILD'S RELATIONSHIP TO PEERS:

_____

METHODS OF DISCIPLINE AND EFFECTIVENESS:

_____

Child Custody: If the child's parents are separated or divorced, please check which situation applies:

____ Joint Custody - Who has primary residence?: _____

____ Sole Custody - Mother

____ Sole Custody – Father

If shared visitation, what is the typical visitation schedule?: _____

_____

I appreciate the opportunity to help enhance the quality of your life.

All appointments must be changed or cancelled 24 hours in advance to avoid a $40.00 charge.

It is the responsibility of the parent signing this form, not the therapist, to notify the child's other parent that his, or her, child is participating in counseling.

I certify that the information on this sheet is correct, and hereby authorize Cristina Mantilla, LLC, to provide therapy, counseling, or other psychiatric and/or psychological services as discussed in the preliminary treatment plan necessary for the client named above. I also authorize the release of medical, psychological, alcohol, drug abuse, and psychiatric information necessary to provide therapeutic services, to collect fees for service from insurers or other third party payors, and for continuity of care between Cristina Mantilla, LLC and other professionals who also provide services for the client.

_____ _____
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THERAPIST SIGNATURE DATE

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CLIENT ORIENTATION

Program Rules :

1. Cristina Mantilla, LLC will provide outpatient counseling, evaluation, information and/or referral.
2. No drug or alcohol screening or "search and seizure" methods will be employed.
3. Client is expected to pay for services when services are rendered. If for any reason payment of services is received back from clients' financial institution (e.g. NSF fee from bank) there will be a $40.00 fee collected prior to next appointment.
4. Clients must not be under the influence of alcohol or illegal substances at the time of the scheduled session. Should the client be under the influence of substances other than prescribed medication the session will be cancelled by the counselor and the client will be expected to pay for the session at the usual, agreed upon, fee.
5. Except in cases of emergency, **cancellations must be made 24 hours in advance**; failure to give 24 hour notice will be considered a "no show" and billed a **$40.00 fee**.

Program Procedures :

1. Client's rights to confidentiality will be observed at all times, with the following exceptions:
- In cases of probable imminent danger to self or others.
- In cases of child abuse, including sexual abuse.
- Communicable diseases must be reported by the counselor to the appropriate county health department.

or

- When you, the client, request that we release information. Information is only shared with other entities

(i.e.: doctors, insurance companies, etc.) when you request it by signing an Authorization to Release Information form. In accordance with HIPPA privacy regulations, any information shared will reveal only the basic minimum information necessary.

2. We reserve the right to release only a Treatment Summary instead of detailed case notes.
3. A minimum requirement of 72 hours is needed for medical records, once a written request is received.
4. The undersigned will neither individually nor jointly involve the therapist or Cristina Mantilla, LLC (and it's staff) in any litigation. The undersigned will neither request nor require that Cristina Mantilla, LLC or the therapist provide testimony in court. The reason for this is so that treatment is not compromised, the therapeutic relationship with the family is maintained, and a child can experience his or her play therapist in a clear, consistent, therapeutic role and not as an assessor or detective. If the services of a mental health professional are desired for court purpose, the services of a person outside of Cristina Mantilla, LLC must be enlisted.

I appreciate the opportunity to help enhance the quality of your life.

Counseling Recordings/Artwork: The use of video recording or photography is sometimes necessary in therapy. Any type of recording is used to provide feedback to you, the client, or for therapist training purposes. Your confidentiality is protected and recordings are erased after each session unless your permission is given for another use. In the case of video or audio recording, you would be informed ahead of time and your written permission would be needed. The use of photography typically involves pictures of children's play structures (i.e.: sand trays, block building, etc.) or pictures of the children with our therapy pet. Children are offered copies of the pictures and this often helps them extend the therapy program to home and school. Artwork is sometimes used for training purposes, but the child's identity is protected. If you have any questions about this, please ask your therapist.

After Hours Emergencies: In the event of a behavioral health emergency, contact 911, National Suicide Prevention Line at: 1-800-273-TALK or go to the nearest crisis center.

Payment of Fees for Service:
1. We accept cash, check, Visa, or insurance reimbursement.
2. If a check is returned for insufficient funds, you will be required to pay any bank service charges in addition to the check amount.
3. All co-pays and private pay fees are due at the time counseling services are provided.

I appreciate the opportunity to help enhance the quality of your life.

Acknowledgement/Consent:

I authorize the Release of Medical information necessary for my insurance company to process my claim. I also authorize the payment of benefits to Cristina Mantilla, LLC.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

I certify all information on the counseling intake forms is true and correct to the best of my knowledge. I will notify Cristina Mantilla of any changes to my insurance information, address, telephone numbers, and any other relevant changes.

By signing this form I am acknowledging receipt of a copy of this paper and in agreement with the Orientation terms and conditions as provided by Cristina Mantilla, LLC.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
THERAPIST SIGNATURE DATE

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