CAROLE KUNKLE-MILLER, PH.D. & ASSOCIATES

520 Washington Road, Suite 206♦ Pittsburgh, Pa. 15228♦412-561-6776
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CONFIDENTIAL INTAKE INFORMATION FOR CHILD
Pl ease Print Clearly

Child's Name: ______________________________ Child's Nickname: ____________________
Last First MI

Address: ____________________________City:__________________ State:______Zip: ______

Home Phone: □________________Cell Phone: □________________Cell phone provider: □______________

(Check how you want to be reached for appointment reminders?) Email? Text message on cell? Voice mail on phone?

Age: ______ Date of Birth: ______________ Sex: M F Child's Social Security # __________________

School:____Grade: ____________________

Parent's Marital Status (please circle one): Single Married Separated Divorced* Domestic Partnership Widowed

Pediatrician: ____________________________________ Phone: ____________________________

Date of last physical exam: __________________ Allergies:______________________________________

Previous psychological or psychiatric contacts: ____

Have you been seen in this private practice previously? Y/N

Person to contact in an emergency: ______________________________ Phone:____________________

Person responsible for insurance: ____

Email Address:____

May we add you to our electronic newsletter list? YES NO (Email workshop/resource info, all addresses are kept private.)

Who referred you to our practice?____

INSURANCE INFORMATION

Insurance Company: ________________________________ Plan Name: ______________________________

Policy Subscriber Name:______________________________ Relationship to Subscriber:__________________

Policy Subscriber Date of Birth:________________________ Subscribers Employer: ______________________

Policy Subscriber Social Security #:_____________________ Employment Status: (full, part-time, retired) __________

Patient ID Number:_________________________________ Group Number:___________________________

____ ____________________
Signature of Responsible Party Date

CONSENT FOR TREATMENT; PHI may be used and disclosed to carryout treatment, payment, or health care operations.

Patient Name: ______________________

(continue to next page)

Patient Name: ____________________

FINANCIAL RESPONSIBILITY AND FEE AGREEMENT

Thank you for choosing Carole Kunkle-Miller, Ph.D. and Associates. In order to better serve you we ask you to understand and agree to the following. The fee for service is $300.00 for initial visit and $200.00 for Individual and Family visits. Except for brief phone contacts, you will be charged for phone therapy, report writing, emails or other professional services (letters, phone, and faxes to outside parties) at the rate of $200.00 per hour. Your insurance company will not reimburse for these services. Legal testimony fees differ from the therapy fees.

To pay for these services, you may select one of the following payment plans:

Payment in full after each session. Our providers do not participate in all insurance plans, under these plans, payment is required in full at the time of service. You may request a receipt to submit to your insurance company.

Payment by insurance company. Your health insurance may cover a portion of the fee. Deductible and co-payment amounts are your responsibility and are due at each session. Due to variation from one policy to another, we cannot guarantee insurance reimbursement. You are responsible for any fees not covered or not paid by insurance regardless of the reason and for denied claims that exceed your benefit limit. Your signature below grants our office permission to file claims and collect payments on your behalf.

Members Responsibilities:

- Pay Co-payments and deductible at the time of service.
- Give at least 24 hours notice of cancellation of an appointment
- Contact your insurance company to determine your benefit limitations and financial obligations (co-payment, deductibles, authorizations, limit of number of visits per year, etc) and to verify that the provider participates with your insurance.
- Obtain authorization for office visits. If your insurance requires a pre-authorization at the time of your visit, we must have it on record. If you fail to obtain proper authorization, you are responsible for payment of any denied claim.
- Notify this office immediately of any changes in the status of your insurance coverage to ensure proper billing.

IMPORTANT OFFICE POLICIES AND PROCEDURES

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure required by law.

Cancellations/No Shows

A minimum of 24 hours notice is required (48 hours notice is preferred) of ANY appointment that you need to cancel. You will be charged $50.00 for appointments forgotten or cancelled without 24 hours advanced notice. Insurance companies will not reimburse for missed appointments; therefore you will be responsible for the total fees.

___________INITIAL

Payment

Please understand that prompt payment for our services is necessary part of your treatment plan. Payments may be made in cash, check or credit card. A fee of $35.00 will be charged for each returned check. Accounts left delinquent more than 90 days could result in the account being turned over to a professional collection service. Late fees or interest may accrue for late payment of balances.

_____________INITIAL

Minor Patients of Separated or Divorced Parents

The adult accompanying the patient must pay at the time of services regardless of who the responsible party is. We cannot become involved in the mediation of financial arrangements between parents. Unaccompanied minors should be provided with payment for their visit and will be expected to be responsible for scheduled appointments. We MUST have permission from BOTH parents. This will be discussed at length at the evaluation session.

___________ INITIAL

Contact/Emergencies

Due to our schedules, the telephone is answered by voice mail or an answering service. Patients with emergencies should call the answering service at 412-571-5989, and ask the operator to page YOUR therapist. We will get back in touch with you as soon as possible.

I CERTIFY THAT I HAVE READ THE ABOVE AND AGREE TO MY FINANCIAL RESPONSIBILITIES.

______________________________ ______________________________

Parent (mother) Signature Parent (father) Signature

______________________________ ______________________________

Date Date

Patient Name: ____________________

MEDICAL HISTORY

Has your child had any hospitalizations, operations or serious medical problems in the past year? Please specify:

____

____

Has your child or any blood relatives had the following:

	Child	Mother	Father	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Brothers	Sisters	Children	Other
Alcoholism											
Drug Addiction											
Anemia											
Asthma											
Cancer											
Diabetes											
Epilepsy											
Heart Disease											
High Blood Pressure											
Low Blood Pressure											
Stroke											
Hepatitis											
Kidney Disease											
Hospitalized for Psychiatric Treatment											
Suicide attempts											
Depression											
Manic Depression											
Anxiety, Fears, Phobias											
ADHD, ADD											
Learning disabilities											
Behavior problems											

MEDICATIONS

Prescribing Physician: ______________________________Telephone: ________________

Physician Address:____

Start Date	Name of Medication	Dosage	Patient Response

Patient Name: ______________________

MEDICAL HISTORY Cont.

Illnesses (Please Specify and Give Dates) Dates

____

____

____

HOSPITALIZATIONS

Reasons for hospitalization Hospital Dates (mo./yr.)

____

____

____

Other medical treatment in or out of hospital (give circumstances and dates):

____

____

____

Has the child ever been in an accident? ____

Has the child ever had any broken bones? ____

Is there a history of problems regarding any of the following? Please describe.

Eating: ____

____

Sleeping: ____

____

Vision: ____

____

Hearing: ____

____

Speech: ____

____

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE CHILD'S BIOLOGICAL PARENTS:

MOTHER

Name: ______________________________ Date of Birth ______________________

Family members' mother grew up with: ____

Family members' mother did not live with: ____

Education level completed: ____

Past and current types of employment (including dates): ____

____

Previous marriages (dates and duration): ____

Date of marriage to child's father (if applicable): ____

Date of separation to child's father (if applicable): ____

Date of current marriage: ____

Patient Name: ____________________

Number of pregnancies: ______living children _______deceased children ________miscarriages ________abortions______

FATHER

Name: ____Date of Birth: ______________________

Family members' father grew up with: ____

Family members' father did not live with:____

Education level completed: ____

Past and current types of employment (including dates): ____

____

Previous marriages (dates and duration):____

Date of marriage to child's mother (if applicable): ____

Date of separation to child's mother (if applicable): ____

Date of current marriage:____

Children from other marriages or relationships (please include birth dates and/or current ages, deceased children should also be listed):

____

____

____

MOTHER'S MEDICAL HISTORY DURING PREGNANCY:

Was the pregnancy planned? Yes__________No__________

What was the mother's health during pregnancy?____

Illness: (For example: kidney diseases, German measles, high blood pressure, etc.)______________________________

____

Medication, X-rays, special diet ____

Accidents/Falls ____

Emotional stress____

Alcohol use ____

Drug use____

Cigarette smoking ____

Caffeine use____

BIRTH HISTORY

Was the child full term? Yes__________No__________

If no, how many weeks premature was delivery? ____

Labor was: Easy____________Difficult____________Duration of labor:____________Child's birth weight___________

Other special circumstances of delivery: (natural childbirth, cesarean, breech, medications, etc.)

____

____

Infant required oxygen _____blood transfusions______ had difficulty breathing ______vomited _______was listless______?

Were mother and infant discharged from the hospital together? Yes__________No__________

Patient Name: ______________________

CHILD DEVELOPMENT HISTORY

Family Members

Name	D.O.B.	Relationship to Child	Where Currently Living

Is your child foster or adopted?____________If so, when?______________If adopted, does the child know? ____________

Infant was breast fed_____until age_______/Infant was bottel fed_______until age_______.

How did the child adjust to weaning?_______________________

Was the child restless? ______ “good Baby”? _______”fussy Baby”? _______happy?________

Any problems with vomiting_______constipation_______colic_______rash_______

At what age (in months) did the child achieve the following developmental milestones:

Rolled over____________ walked____________sat up____________crawled_____________talked____________

Toilet training: Bladder – Begin/complete _______________/_______________

Bowel – Begin/ complete _______________/_______________

Did the child revert to soiling or wetting (during the day or night)? ____

Specify any problems ____

Has the child ever been separated from either parent for more than one day or an evening? Yes_______ No_________

If Yes, give dates and reasons ____

____

Who cared for the child during these times? ____

Did the child ever lose any person with whom he/she seemed to have a close relationship, such as father, mother, sister, brother, grandparent, or others? (Specify relationship to child, type of loss/death/relocation/divorce and date this occurred.)

____

____

____

Has the child reached puberty? Yes______________ No_______________ If Yes, at what age:________________

If female, when did menstruation begin?_______________________________

Please list any other medical problems or handicaps the child has had:

____

____

What is the chief concern you have about the child?____

____

What is the child’s attitude toward his/her problem?____

____

When did their problems begin or how long have they been present?_____________________________________

____

Patient Name: ______________________

EDUCATIONAL HISTORY

Preschool or School   Dates Attended   Highest Grade Completed

____

____

____

Has the child ever repeated a grade? Yes______________ No______________

If Yes, please state which grade and for what reason: ______________________

____

Special classes attended? ______________________

Has IEP or Service Agreement? ______________________

School suspension and why: ______________________

Attitude toward school (enthusiastic, indifferent, poor) ______________________

Any problems experienced in school? ______________________

____

SOCIAL FUNCTIONING

Please list any and all groups or organizations to which your child has belonged, such as scouts, clubs, church groups, etc.)

Group   Time period attended   Frequency

____

____

____

Please list any areas of special concern in additional to referral problem (e.g., making friends, temper, not telling the truth, taking things that belong to others, mood changes, drug/alcohol use, acting younger than age)

____

____

In general, how does your child express feelings? ______________________

____

What manner of discipline do you employ (time out, going to room, etc.) ______________________

____

How does child occupy his/her time? ______________________

____

LIFESTYLE (for children age 12 and older, ask him or her to complete)

Do you smoke cigarettes? Yes No If so, indicate how many per day: ______________________

Do you drink caffeine? Yes No If so, indicate how many servings per day: ______________________

Do you drink alcohol? Yes No

If so, please indicate what kind you drink and how many drinks you have per week:

____

Do you use drugs recreationally? Yes No

If yes, please indicate the type of drug and how often it is used: ______________________

Do you exercise? Yes No

If yes, please indicate the type of activity and times per week that you engage in the activity: ______________________

____

Patient Name: ______________________

Do you have what you consider to be a weight or eating problem? Yes No

If so, please describe:____

Do you have any hobbies or special interests? Yes No

If yes, please indicate what type and the amount of time per week spent engaged in this interest:________________________

____

How do you typically spend your free time? ____

____

____

CHILD BEHAVIOR CHECKLIST FOR AGES 4-16 (To be completed by parent)

I. Please list the sports your child most likes to take part in. For example, swimming baseball, skating, skateboarding, etc.
☐ None

Compared to other children of the same age, about how much time does he/she spend in each?

Compared to other children of the same age, how well does he/she do each one?

Sport	Don't Know	Less than average	Average	More than average	Don't	Below average	Average	Above Average
a. ________	☐	☐	☐	☐	☐	☐	☐	☐
b. ________	☐	☐	☐	☐	☐	☐	☐	☐
c. ________	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include TV)
☐ None

Compared to other children of the same age, about how much time does he/she spend in each?

Compared to other children of the same age, how well does he/she do each one?

Hobby	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. ________	☐	☐	☐	☐	☐	☐	☐	☐
b. ________	☐	☐	☐	☐	☐	☐	☐	☐
c. ________	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs Teams, or groups you child belongs to:
☐ None

Compared to other children of the same age, how active is he/she in each?

Organization	Don't Know	Less active	Average	More active
a. ________	☐	☐	☐	☐
b. ________	☐	☐	☐	☐
c. ________	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting making bed, etc.
☐ None

Compared to other children of the same age, how well does he/she carry them out?

Job/Chore	Don't Know	Below average	Average	Above average
a. ________	☐	☐	☐	☐
b. ________	☐	☐	☐	☐
c. ________	☐	☐	☐	☐

V. About how many close friends does your child have? ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

About how many times a week does your child do things with them? ☐ Less than 1 ☐ 2 or 3 ☐ 4 or more

VI. Compared to other children of his/her age, how well does your child:

	Worse	About the Same	Better
a. Get along with his/her brothers & sisters?	☐	☐	☐

Patient Name: ______________________

b.	Get along with other children?	☐	☐	☐
c.	Behave with his/her parents?	☐	☐	☐
d.	Play and work by himself/herself?	☐	☐	☐

VII. 1. Current school performance – for children aged 6 and older?

☐ Does not go to school

	Failing	Below Average	Average	Above Average
a. Reading or English	☐	☐	☐	☐
b. Writing	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Spelling	☐	☐	☐	☐
e. ___________________________	☐	☐	☐	☐
f. ___________________________	☐	☐	☐	☐
g. ___________________________	☐	☐	☐	☐

2. Is your child in a special class?

   ☐ No ☐ Yes-what kind?____

3. Has your child ever repeated a grade?

   ☐ No ☐ Yes-grade and reason

4. Has your child had any academic or other problems in school?

   ☐ No ☐ Yes-please describe

   When did these problems start?____

   Have these problems ended? ☐ No ☐ Yes-when?____

VIII. Below is a list of items that describe children. For each item that describes your child now or within the past 6 months please circle: the **2** if the item is *very true or often true* of your child. Circle the **1** if the item is *somewhat or sometimes true* of your child. If the item is *not true* of your child, circle the **0**.

0 1 2 1. Acts too young for his/her age
0 1 2 2. Argues a lot
0 1 2 3. Behaves like the opposite sex
0 1 2 4. Bowel movements outside toilet
0 1 2 5. Bragging, boasting
0 1 2 6. Can't concentrate or pay attention long
0 1 2 7. Can't get his/her mind off certain thoughts, obsessions (describe):
____
____
____
0 1 2 8. Can't sit still, restless, or hyperactive
0 1 2 9. Clings to adults or too dependent
0 1 2 10. Complains of loneliness
0 1 2 11. Confused or seems to be in a fog
0 1 2 12. Cries a lot
0 1 2 13. Cruel to animals
0 1 2 14. Cruelty, bulling, or meanness to others
0 1 2 15. Day-dreams or gets lost in her/her thoughts
0 1 2 16. Deliberately harms self or attempts suicide
0 1 2 17. Demands a lot of attention
0 1 2 18. Destroys his/her own things
0 1 2 19. Destroys things belonging to others
0 1 2 20. Disobedient at home
0 1 2 21. Disobedient at school
0 1 2 22. Doesn't eat well
0 1 2 23. Doesn't get along with other children
0 1 2 24. Doesn't seem to feel guilty after misbehaving
0 1 2 26. Eats or drinks things that are not food (describe)________________________
____
0 1 2 27. Fears certain animals, situations, or places, other than school (describe):
____
____
0 1 2 28. Fears going to school
0 1 2 29. Fears he/she might think or do something bad
0 1 2 30. Feels he/she has to be perfect
0 1 2 31. Feels/complains no one loves him/her
0 1 2 32. Feels others are out to get him/her
0 1 2 33. Feels worthless or inferior
0 1 2 34. Gets hurt a lot (accident prone)
0 1 2 35. Gets in many fights
0 1 2 36. Gets teased a lot
0 1 2 37. Hangs around with children who get in trouble
0 1 2 38. Hears things that aren't there (describe):
____
____
0 1 2 39. Impulsive or acts without thinking
0 1 2 40. Likes to be alone
0 1 2 41. Lying or cheating
0 1 2 42. Bites fingernails
0 1 2 43. Nervous, high-strung, or tense
0 1 2 44. Nervous movements or twitching_____ (describe); _______________________

Patient Name: ______________________

0 1 2 45. Nightmares
0 1 2 46. Not liked by other children
0 1 2 47. Constipated, doesn't move bowels
0 1 2 48. Too fearful or anxious
0 1 2 49. Feels dizzy
0 1 2 50. Feels too guilty
0 1 2 51. Overeating
0 1 2 52. Overtired
0 1 2 53. Overweight
0 1 2 54. Physical problems without known medical causes:
0 1 2 a. Aches or pains
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (describe) ________________________________
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe) _________________
0 1 2 55. Physically attacks people
0 1 2 56. Picks nose, skin or other parts of body (describe)_________________________
0 1 2 57. Plays with own sex parts in public
0 1 2 58. Plays with own sex parts too much
0 1 2 59. Poor school work
0 1 2 60. Poorly coordinated or clumsy
0 1 2 61. Prefers playing with older children
0 1 2 62. Prefers playing with younger children
0 1 2 63. Refuses to talk
0 1 2 64. Repeats certain acts over and over; compulsions (describe) ______________ ________________________________
0 1 2 65. Runs away from home
0 1 2 66. Screams a lot
0 1 2 67. Secretive, keeps things to self
0 1 2 68. Sees things that aren't there (describe) ________________________________
0 1 2 69. Self-conscious or easily embarrassed
0 1 2 70. Sets fires
0 1 2 71. Sexual problems (describe): __________ ________________________________
0 1 2 72. Showing off or clowning
0 1 2 73. Shy or timid
0 1 2 74. Sleeps less than most children
0 1 2 75. Sleeps more than most children during day and/or night (describe) ______________ ________________________________
0 1 2 76. Smears or plays with bowel movements
0 1 2 77. Speech problem (describe) __________ ________________________________
0 1 2 78. Stares blankly
0 1 2 79. Steals at home
0 1 2 80. Steals outside the home
0 1 2 81. Stores up things he/she doesn't need (describe): ______________________
0 1 2 82. Strange behavior (describe) _________ ________________________________
0 1 2 83. Strange ideas (describe):____________ ________________________________
0 1 2 84. Stubborn, sullen, or irritable
0 1 2 85. Sudden changes in mood or feelings
0 1 2 86. Sulks a lot
0 1 2 87. Suspicious
0 1 2 88. Swearing or obscene language
0 1 2 89. Talks about killing self
0 1 2 90. Talks or walks in sleep (describe): ________________________________
0 1 2 91. Talks too much
0 1 2 92. Teases a lot
0 1 2 93. Temper tantrums or hot temper
0 1 2 94. Thinks about sex too much
0 1 2 95. Threatens people
0 1 2 96. Thumb-sucking
0 1 2 97. Too concerned with neatness or cleanliness
0 1 2 98. Trouble sleeping (describe __________ ________________________________
0 1 2 99. Truancy, skips school
0 1 2 100. Underactive, slow moving, lacks energy
0 1 2 101. Unhappy, sad, or depressed
0 1 2 102. Unusually loud
0 1 2 103. Uses alcohol or drugs (describe): _____ ________________________________
0 1 2 104. Vandalism
0 1 2 105. Wets self during the day
0 1 2 106. Wets the bed
0 1 2 107. Whining
0 1 2 108. Wishes to be of opposite sex
0 1 2 109. Withdrawn, doesn't get involved with others
0 1 2 110. Worrying
0 1 2 111. Please write in any problems you child
____
____
____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS **UNDERLINE ANY YOU ARE CONCERNED ABOUT**

Please use this space to provide any additional family or personal information which might be helpful in assessing your child for treatment:

____
____
____

____________________________ ____

Date **Signature of person completing form/relationship to child**