DRCoughlin
Licensed Mental Health Counselor

1101 South Belcher Road Suite E
Largo, FL 33771
(727) 532-1997 Fax (727) 524-1332

INTAKE FOR A MINOR

Name _____ **SS#** _____ **Date** _____

Date of Birth _____ Age _____ Current Grade in School _____

Home Address _____

City _____ Zip Code _____

Schools Attended:

Elementary _____

Middle School _____

High School _____

Parent or Guardian (1) (Please fill out this section)

Parent/Guardian Name _____

Home Phone _____ Cell _____

Home Address (if different from dependent) _____

City: _____ Zip Code: _____

Email: _____

Parent or Guardian (2) (Please fill out this section)

Parent/Guardian Name _____

Home Phone _____ Cell _____

Home Address (if different from dependent) _____

City: _____ Zip Code: _____

Email: _____

Pediatrician: _____ Phone _____

Address:_____

City: _____ Zip Code: _____

Person responsible for payment: _____ Relationship: _____

Driver's License Number: _____ State: _____

Address: _____

City: _____ Zip Code: _____

Family Members:

	Name	Age	Sex	Occupation	Live w/parent?
Father					
Mother					
Siblings					

Please list other persons living in the household with the patient:

Name	Age	Sex	Relation to Patient

Medical Information:

Has the patient had previous psychological treatment? **YES ☐ NO ☐**

If so, with whom and for what reason?:_____

_____

Has individual testing been performed at school? **YES ☐ NO ☐**

Family history of past serious illnesses, familial disease, including drug addiction and/or alcoholism: _____

_____

_____

MEDICAL QUESTIONAIRE

What medical problems, if any, is your child currently experiencing?

_____

_____

Are those problems being treated? **YES** ☐ **NO** ☐

By whom? _____

Last medical examination (date): _____

Primary care doctor: _____

Current medication (if any):

_____

_____

Prescribing Physician: _____

List past hospitalizations, operations, or serious illnesses:

- _____

Year: _____

- _____

Year: _____

- _____

Year: _____

- _____

Year: _____

Check any of the following medical problems your child has experienced:

☐ Colic
☐ Chronic ear infections
☐ Measles
☐ Strep infection
☐ Skin problems
☐ Asthma
☐ Allergies
☐ Broken bones
☐ Tonsillitis
☐ Urinary tract infections
☐ Other_____

What is your child's usual sleep pattern?

_____

_____

_____

Describe usual eating pattern, food preferences, and any problems with weight or diet.

Has your child used drugs or alcohol (to your knowledge)? If yes, please describe:

Has there been any known or suspected child abuse (verbal, physical, or sexual)? If yes, please explain.

Are there any concerns about sexual development?

Is your child sexually active? Yes_____ No_____

Please list any other areas of concern and provide additional information as needed.

WENDY E. COUGHLIN Ph.D., L.M.H.C.
Independent Psychotherapy Associates P.A.

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Largo, FL 33771 **Fax: (727) 524-1332**

PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your prior Consent. The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The Practice may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by _____
Patient Signature or Representative Date

Relationship to Patient (If other then patient): _____

Witness: _____
Date: _____