Gabriel Villarreal
Resident in Counseling
**Child Intake Form**

Child's Name _____DOB_____ Age_____

Gender_____ School_____ Grade _____

Street_____ City_____State_____ Zip_____

Your Name and Relationhip to Child_____ Your DOB_____

Home phone_____ May we call you at home? ____Cell phone _____ May we call your cell? _____

Your SSN_____Employer_____ Work phone _____ May we call you at work?_____

Marital Status _____ Spouse's Name_____ DOB_____

Spouse's SSN _____ Spouse's Employer_____ Work phone_____

In case we can not contact you and need to leave a message, whom should we contact?

Name_____ Telephone Number_____ Relationship_____

How did you learn about my counseling services?
( ) Friend, ( ) Family, ( ) Internet, ( ) Physician, ( ) Other _____

## Insurance/Waiver Information

Some insurance companies will provide coverage for counseling services, but benefits vary from company to company and policy to policy. **It is your responsibility to contact your insurance company and verify that I am a participating provider with them and my services are a covered benefit under your policy.** It is also your responsibility to obtain the initial authorization for services if required by your insurance. It is not possible to get retroactive authorization. Failure to do so may result in your insurance company denying payment for services rendered, therefore making the full charge your responsibility. My office staff will file your insurance claims for you. I understand that and accept that without providing a current insurance card and/or authorization number, I assume all financial responsibility for my therapy session(s) at the full rate and I release Gabriel Villarreal, Resident in Counseling from any and all terms and restrictions of my insurance company. This waiver begins with my session on _____.

_____ _____
Signature of Responsible Party Date

## Release of Information

I authorize Gabriel Villarreal, Resident in Counseling to release information about this client to my medical insurance company and referring professional. This authorization will end at any time that I have given written instructions to that effect to Gabriel Villarreal, Resident in Counseling.

_____
Signature of Responsible Party Date

**Practice Policies**

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**Tanglewood Counseling and Psychology** consists of four mental health professionals. We are each in independent practice. We are not a partnership and we do not see one another's clients unless a consultation is specifically requested.

**Fees and Insurance:** Initial sessions are charged at a rate of $150.00 with subsequent sessions charged at a rate of $135.00. The initial charge reflects the additional time needed for consultation with previous therapist, referring professional, and insurance companies requiring documentation for authorization of additional services. If you forget an appointment or fail to provide a 24 hour notice for cancellation, you will be charged for the session. Exceptions are made for acute illnesses or emergencies.. This charge in not covered by insurance plans.

I hereby agree to pay for services rendered and for appointments not kept without 24 hours advance notice of cancellation to Gabriel Villarreal, Resident in Counseling when the charge is incurred. There is a $35.00 return check fee. In the event of default, I promise to pay legal interest on the indebtedness, together with such collections coss and/or fees required to effect collection. I understand that my name, address, SS number, phone number, date of birth, employer name, address,and phone, date of service and charge will be released to the collection agency.

_____ _____

Signature of Responsible Party Date

I authorize my medical insurance company to pay Gabriel Villarreal, Resident in Counseling directly for her services. I agree that I remain responsible for all fees not paid by my insurance. Gabriel Villarreal will honor any insurance plan payment schedule for any insurer with whom she is a participating provider.

_____ _____

Signature of Responsible Party Date

**Weather Closings:** My office will notify you if the office is closed due to inclement weather. I will make every attempt to reschedule any canceled appointments as soon as possible.

**Crisis:** My office is not set up to routinely provide crisis intervention services. If you experience an emergency requiring immediate attention while the office is closed,please telephone the 24 hour hotline through emergency Outreach Services (540-981-9351), RESPOND at Lewis Gale Psychiatric Center (540-776-1100), or CONNECT at Roanoke Memorial Hospital (540-981-8181), or go to your nearest hospital emergency room. If you need to speak with me directly during regular office hours (Monday - Thursday 9am - 6pm), please leave your name and telephone number with my office manager (772-1872). I will return your call as soon as possible. After office hours and when my office manager is not in, voice mail is available to receive messages. On evenings, weekends, and holiday, the message will be received and acted upon during the next working day.

Account balance, insurance questions, and **ALL** scheduling or canceling of appointments **MUST** be directed to Mrs. Angela Dooley. She is in the office Monday - Thursday between 8:00am and 4:30pm. Angela can also be reached by email at angela.tcp@hotmail.com.
I would appreciate your signature below signifying that you have read, understood, and accepted the above conditions.

_____ _____

Signature of Responsible Party Date

_____

Printed Name of Responsible Party

**Presenting Challenges**

Gabriel Villarreal
Resident in Counseling

# Child Intake Form

**Chief Complaint:**

What brought you to seek counseling for your child?

How long has this challenge existed and what are the precipitating events?

**Please check all that apply to your child:**

| | | | |
|---|---|---|---|
| ( ) suicidal | ( )falls a lot | ( )bumps into things | ( ) gets along with children his/her age |
| ( ) agitation | ( ) vomiting | ( ) work absences | ( ) fights a great deal with other children |
| ( ) has a lot of fears | ( ) dread school | ( )seems to like toys/objects better than people | |
| ( ) diarrhea | ( )active without stopping | ( ) school absences | ( )sits quietly for long periods of time |
| ( ) headaches | ( ) nightmares | ( )is a graceful child | ( )is a likeable child |
| ( )wets during day/night | ( )soils self | ( )does well in school | ( )is destructive or cruel to animals |
| ( ) irritable | ( ) frequent temper tantrums | ( )difficulty making friends | ( ) can't concentrate |
| ( )blank or staring spells | ( )disorganized | ( )short attention span | ( ) increased arguments |
| ( )requires a lot of attention | ( ) withdrawn | ( ) academic challenges | ( ) failed/repeated grade |
| ( )seems anxious | ( ) self harm | ( )seems sad | ( ) avoid family members |
| ( )has an IEP/504 plan | ( ) cries easily/often | ( ) stubborn | ( ) impulsive |
| ( ) compulsive behaviors | ( ) avoid friends | ( ) excessive sleep. | ( ) difficulty sleeping |
| ( ) panic | ( ) violent behavior | ( ) obsessive worry | ( ) blackouts |
| ( ) hallucinations | ( ) poor appetite | ( ) excessive eating | ( )use of alcohol or other substances |

What area of your child's life (social,family work, education) has been the most affected? How?

Who have you consulted about this challenge?

Please describe your child's personality.

What are your child's hobbies and recreational activities?

Describe a typical day in your child's life from the time he/she gets up until the time he/she goes to bed at night.

**Medical History**

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# Child Intake Form

Has your child ever had any serious illnesses, convulsions, operations, hospitalizations, head trauma, or other accidents?

_____

_____

_____

Is your child currently prescribed Medications? If so please list name, dosage, and prescribing physician.

_____

_____

_____

## Developmental History

Were there any difficulties during pregnancy?_____ Was the child full term_____
Were any medications or substances used during pregnancy?Describe_____
Type of Delivery? _____omplications with delivery?_____Child's birthweight_____
Relivent events occuring just after birth_____
Describe your child's first year _____
At what approximate age did your child reach the following milestones?
Smile _____ Babble _____ Sit on own _____ Say first word _____ Put sentences together _____
Feed self with fingers _____ Crawl_____Walk without assistance _____ Potty Trained _____

## Substance Us

Describe your use of alcohol, cigarettes, street drugs, over the counter drugs. How much? How often? Does anyone complain?

_____

_____

_____

Describe the same of any family members.

_____

_____

_____

## Family History

| Name | DOB | Education | Medical Health (list past and present concerns and conditions) | Psychiatric Health |
|---|---|---|---|---|
| Child | | | | |
| Mother | | | | |
| Father | | | | |
| Siblings | | | | |
| | | | | |
| | | | | |
| Step Mother | | | | |
| Step Father | | | | |
| Father's Mother | | | | |
| Father's Father | | | | |

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Mother's
Mother_____
Mother's
Father_____

Who presently lives in your household?

_____
_____
_____

Have their been any changes in the management of your household in the past year? If so, in what ways?

_____
_____
_____

Any history of verbal, physical, sexual abuse; please describe

_____
_____
_____

Is there anything else you would like for me to know about your child and/or your family?_____
_____
_____