HEALTH ASSOCIATES
(CHILD INTAKE)

CHILD'S LEGAL NAME: _____ **DOB**: ____ / ____ / _____ **AGE**: _____
Last First M.I.

ADDRESS: _____
Street # City State Zip Code

RACE: _____ **ETHNICITY:** _____ **RELIGIOUS PREFERENCE, IF ANY**: _____

SEX AT BIRTH: M ☐ F ☐ **GENDER IDENTITY**: _____ **PRONOUNS**: SHE/HER ☐ HE/HIM ☐ OTHER ☐

SCHOOL: _____ **GRADE:** _____ **CHILD'S SOCIAL SECURITY #:** _____

CHILD LIVES WITH: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER: _____

PERSON ACCOMPANYING CHILD: _____ **RELATIONSHIP:** _____

PERSON RESPONSIBLE FOR PAYMENT:_____

MOTHER'S NAME: _____
ADDRESS_____
_____
HOME PHONE #: _____
CELL PHONE #: _____
EMPLOYER: _____
WORK ADDRESS: _____
_____
SOCIAL SECURITY #: _____

FATHER'S NAME: _____
ADDRESS: _____
_____
HOME PHONE #: _____
CELL PHONE #: _____
EMPLOYER: _____
WORK ADDRESS: _____
_____
SOCIAL SECURITY #: _____

IF YOU WANT INSURANCE CLAIMS FILED, PLEASE COMPLETE:

NAME OF POLICY HOLDER: _____ **POLICY HOLDER DOB:** _____ / _____ / _____

ADDRESS (IF DIFFERENT FROM ABOVE): _____

POLICY HOLDER'S EMPLOYER: _____ **INSURANCE COMPANY**: _____

INSURANCE CARD ID #: _____ **GROUP** #: _____ **RELATIONSHIP TO PATIENT**: _____

Insurance assignment authorization: I authorize the release of treatment data, including drug and alcohol information, for purposes of claims filing, prior authorization, review of medical necessity or any other request for information by my insurance carrier. I also authorize assignment of all medical and mental health benefits payable under my insurance policy to Health Associates, LLC so they may be applied to my account.

Signature of Guardian/Resp. Party: _____ Date: _____

The remainder of all unpaid charges is the responsibility of the patient unless otherwise stated. Payment is due at the time of service. My signature authorizes Health Associates to process my credit card for any remaining unpaid charges not covered by insurance, including denied claims and missed appointment and/or late cancellation fees.

Credit Card # (required for treatment): _____ Exp. Date: _____ Security Code: _____

Cardholder Signature: _____ Date: _____

PLEASE COMPLETE OTHER SIDE

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU ARE CURRENTLY STRUGGLING WITH:

None = This symptom is not present currently **Mild =** Impacts quality of life, but no significant implication on day-to-day functioning

Moderate = Significant impacts on quality of life and/or day-to-day functioning **Severe =** Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Headaches	( )	( )	( )	( )	Faintness or dizziness	( )	( )	( )	( )
Bad dreams	( )	( )	( )	( )	Feeling fearful	( )	( )	( )	( )
Sweaty palms	( )	( )	( )	( )	Weakness in parts of body	( )	( )	( )	( )
Shakiness	( )	( )	( )	( )	Heart or chest pain	( )	( )	( )	( )
Fatigue	( )	( )	( )	( )	Feeling tense or nervous	( )	( )	( )	( )
Epilepsy	( )	( )	( )	( )	Difficulty concentrating	( )	( )	( )	( )
Hopelessness	( )	( )	( )	( )	Trouble remembering things	( )	( )	( )	( )
Overeating	( )	( )	( )	( )	Obsessive thoughts	( )	( )	( )	( )
Allergies	( )	( )	( )	( )	Difficulty staying asleep	( )	( )	( )	( )
Worrying/stewing	( )	( )	( )	( )	Easily annoyed/ irritated	( )	( )	( )	( )
Difficulty making decisions	( )	( )	( )	( )	Sadness	( )	( )	( )	( )
Lower back pain	( )	( )	( )	( )	Muscle tension	( )	( )	( )	( )
Tightness in stomach	( )	( )	( )	( )	Diabetes	( )	( )	( )	( )
Trouble getting breath	( )	( )	( )	( )	Crying easily	( )	( )	( )	( )
Loss of interest in things	( )	( )	( )	( )	Hot flashes	( )	( )	( )	( )
Difficulty falling asleep	( )	( )	( )	( )	Tightness in jaw	( )	( )	( )	( )
Cold hands or feet	( )	( )	( )	( )	Grinding of teeth	( )	( )	( )	( )
Thoughts of harm to self or others	( )	( )	( )	( )	Dry mouth	( )	( )	( )	( )
Outburst of temper	( )	( )	( )	( )	Feelings of guilt	( )	( )	( )	( )

LIST UP TO THREE ISSUES CAUSING YOU THE *MOST* DIFFICULTY:

1._____ **2**. _____ **3**. _____

List medications you are presently taking and the dosage: _____

_____

KNOWN ALLERGIES: _____

SUBSTANCE USE: (Daily/Weekly/Monthly/Never)

Frequency of tobacco use _____

Frequency of illegal drug use_____

Frequency of alcohol use _____