Staci Lea Rocha, M.A., LPC
8008 Slide Road #31
Lubbock, Texas 79424
Phone: (806) 300-0898 x 7 Fax: (806) 701-5422

ADOLESCENT INTAKE ASSESSMENT FORM

Name_____ Date of 1st Appointment_____Therapist _____

Date of Birth _____ Age _____ Gender: Male_____ Female_____

MEDICAL HISTORY

Name of Primary Care Physician:

_____

Physician's Address:_____

Physician's Phone:_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Current medications being taken:

1)_____ Dosage/Freq _____

Start Date_____Purpose_____

2)_____ Dosage/Freq _____

Start Date_____Purpose_____

3)_____ Dosage/Freq _____

Start Date_____Purpose_____

4)_____ Dosage/Freq _____

Start Date_____Purpose_____

Prescribed by:_____
_____

Date of last medical evaluation:_____ Date of next appointment:_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital Mo/Yr Reason

_____
_____
_____
_____

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Describe any important medical history, chronic ailments, or other health problems you experience:_____

_____

_____

_____

_____

_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic
ailments:_____

_____

_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

_____

_____

_____

SCHOOL AND FAMILY HISTORY

Do you experience any academic problems while in school? (Circle One) YES NO
If yes, please
explain:_____
What was the last year of school you completed? _____What school are you currently attending? _____
Who is in your current support network? (friends, relatives, other
adults):_____

_____

Please check all information which applies to your biological parents:
MOTHER ____ living ____ deceased____ married ____ divorced____ remarried ____# of times
FATHER ____ living____ deceased____ married ____ divorced____ remarried ____# of times
With whom do you live? Mother____ Father____ Stepmother____ Stepfather____ Guardian ____ Grandparent____
Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

_____

_____

List first names and ages of your brothers & sisters:
Name Age Relationship (biological, step, half, etc.) Lives with:

_____

_____

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Others living in the home with you:

Name Age Relationship Grade/Occupation

_____

_____

_____

Describe your relationship with your mother:

Currently:_____

_____

In the

past:_____

_____

Describe your relationship with your father:

Currently:_____

_____

In the

past:_____

Describe your relationship with your

stepmother:_____

_____

Describe your relationship with your

stepfather:_____

_____

Describe any problems that have occurred in your family relating to:

Alcohol/drug

abuse:_____

_____

Sexual/physical/emotional

abuse:_____

_____

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MENTAL STATUS

Please check any of the following that describe how you believe you feel:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful ____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless ___annoyed

Describe any other feelings you have had:_____

_____

Please check any of the following risk-taking behaviors you have engaged in:

___street racing ___gang involvement ___skip school ___dropped out ___dangerous dieting ___cutting ___stealing ___unprotected sex ___running away ___bullying others ___fire starting ___hurt animals ___restrict or restricted food intake ___over exercise

Please check any of the following alcohol/drugs that you currently or have previously used:

____beer ____wine ____hard liquor ____pot ____cocaine ____heroin ____Ecstasy ____speed ___over the counter drugs ____prescription drugs ____ice ____Triple C's ____dones ____quad bars

Other:_____

Have you had any change in sleeping habits? (Circle One) YES NO

Describe:_____

_____

Have you had any change in eating habits? (Circle One) YES NO

Describe:_____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain:_____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain:_____

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LEVEL OF FUNCTIONING

List any current problems you are having in daily psychological, social or school functioning (i.e. isolation from friends/family, significant difficulty getting to school or completing daily tasks, parent's recent divorce or problems with peers, getting along with family members):_____

_____

What activities or hobbies do you participate in?

_____

_____

Do you participate in regular exercise? (Circle One) YES NO

Describe:_____

How much time do you spend online or gaming?_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

_____

Please list your therapy goals:

_____

_____

_____

_____

_____

THANK YOU!

RISE Counseling
Staci Rocha MA LPC
8008 Slide Road #31
Lubbock, Texas 79424
Office: (806) 787-0701 ***Fax: (806) 701-5422***

CARD AUTHORIZATION FORM

Client Name:_____
Date of Birth: _____

The purpose of this form is to authorize Staci Rocha MA LPC to retain a valid credit card number on file for you as our client. All new clients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit card will be charged ONLY under the following circumstances:

1. Staci Rocha MA LPC reserves the right to charge the credit card listed below for all current clients balances, including co-pays (following insurance payments) and a receipt will be kept in your client chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current client balances on your account.

2. If you, as the client, miss a scheduled appointment without 24-hour notice to cancel or reschedule, Staci Rocha MA LPC reserves the right to charge the credit card listed below $50.00 (standard no-show fee) and a receipt will be sent to the current address file. This notice serves as your consent to being charged for any and all no-shows.

3. If we receive notice that a payment is returned to us for any reason, Staci Rocha MA LPC reserves the right to charge the credit card listed below a $25.00 returned check fee as well as the amount of the issued insufficient check. A receipt will be sent to the current address on file. This notice serves as your consent to being charged for any returned payments.

4. Other than the conditions mentioned above, under NO circumstance will Staci Rocha MA LPC charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted: I have read this form and talked with Staci Rocha MA LPC, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X_____ _____
Client or Responsible Party Signature **Date**

X_____ _____
Counselor Signature **Date**

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CARD AUTHORIZATION FORM

NAME, AS IT APPEARS ON CREDIT CARD:_____

BILLING ADDRESS: _____

ZIP CODE: _____

AMEX/DISC/MC/VISA CARD#: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

EXPIRATION DATE: _____/_____

VERIFICATION CODE (3 or 4 DIGITS): ___ ___ ___ ___

Refusal to Complete Authorization:

Refusal to complete and agree to this authorization dictates the following:

Since there is no credit card on file, Staci Rocha MA LPC reserves the right to send only ONE statement to the address on file to notify you of your balance with our practice. It is your responsibility to send the amount due within 30 days of your statement to avoid being sent to collections and having your account closed with our practice.

X_____ _____
Client or Responsible Party Signature **Date**

X_____ _____
Counselor Signature **Date**