Maria Allen-Jenkins, Psy.D., PLLC

Child Intake Form

Client Information

Name: _____ Date: _____
First MI Last

Date of Birth: _____ Age: _____ Gender: _____

Address: _____
Street Apt. Number

_____
City County State Zip

Client's Phone: Home: (____)_____ Work: (____)_____ Cell: (____)_____
Is it ok for me to leave a message for you at these numbers? _____

If minor, name of legal guardian(s): _____

Place of Employment/School: _____

Legal/Marital Status: Single Married Divorced Separated Widowed Other: _____

Emergency Contact Information*

*If client is a minor, please provide at least two people (usually parents, guardians, or close family) who may be contacted during an emergency.

Name: _____ Relation: _____
First MI Last

Phone: Home: (____)_____ Work: (____)_____ Cell: (____)_____

Name: _____ Relation: _____
First MI Last

Phone: Home: (____)_____ Work: (____)_____ Cell: (____)_____

Payment Information

Would you like us to bill your insurance? Yes ____ No ____

If yes, what insurance company? _____

Policy holder name: _____ Date of Birth: _____
First MI Last

Policy holder's phone number: _____ Employer: _____

Policy holder's address: _____

Please list any secondary insurance and/or other organization subsidizing payments:

_____

Appointment Reminders

If you are interested in receiving email reminders about future appointments, please clearly write the appropriate email address below.

Email Address: _____

The emails are sent through a secure server via the company Therapy Notes. However, it is never a guarantee that email communication is completely secure. This service is optional.

Familial Information

Birth Parents' Names and Ages (Please explain any custody agreements): _____
_____

Guardians' Names if different from birth parents: _____

Siblings' Names and Ages: _____
_____

Any additional people living in the household: _____
_____

Were any developmental milestones delayed (sitting up, walking, talking, toilet training)? If so, please explain. _____
_____
_____

Spiritual Information

Does your family have a spiritual affiliation? ☐ Yes ☐ No

If yes, what is your spiritual affiliation? _____

Where, if anywhere, do you worship? _____

Educational History

Child's current grade: _____ School: _____

What grades, if any, have been repeated? _____

Please explain any suspensions or expulsions from school, if any. _____
_____
_____

Medical History

Name of Primary Care Physician: _____ Phone: _____

Address: _____
Street City State Zip

Name of Psychiatrist: _____ Phone: _____

Address: _____
Street City State Zip

Current Medications:

Medication	Dosage	Prescribing Doctor	Reason Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations – Psychiatric, Chemical Dependency:

Dates	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any medical conditions, including allergies: _____
_____

If you are interested in signing a consent form giving Dr. Allen-Jenkins permission to communicate openly with the client's primary care physician and/or psychiatrist regarding his or her treatment with Dr. Allen-Jenkins, please complete the Authorization for Release of Records and Information From located at the end of this packet. Otherwise, please check the option below declining release.

☐ I do **not** give permission for Dr. Allen-Jenkins to communicate with the client's primary care Physician at this time.

(Note: You may change this answer at any time during or after treatment.)

Legal History

Custody Issues: _____

Other Family Court involvement: _____

Other legal involvement: _____

Psychiatric Information

Has the child had counseling previously? ☐ Yes ☐ No

If so, please list previous practitioners, dates of treatment, and response to treatment.

_____
_____
_____

Has the child been treated with any psychiatric medications? ☐ Yes ☐ No

If yes, which medications have been tried, were they effective, and why did he/she stop taking them?

_____
_____
_____

What are the reasons you are seeking counseling at this time? _____
_____
_____
_____

What specific goals do you plan to work on during each counseling session?

1. _____
2. _____
3. _____
4. _____

Substance Use History

Substance	Amount	Frequency	First Use	Last Use
Caffeine				
Tobacco				
Alcohol				
Marijuana				
Narcotics				
Amphetamines				
Hallucinogens				
Cocaine				
Others:				

History of substance abuse: _____
_____

Previous or current treatment for substance abuse: _____
_____

Family history of substance abuse: _____
_____

Signature of Individual Completing Form: _____ Date: _____

Signature Page

Client Name: _____

DOB: _____

**Note to client: In order to complete this page, you must read the Maria Allen-Jenkins. Psy.D., PLLC Policy Binder. The Policy Binder is also available on www.DrMariaAllenJenkins.com. Please notify Dr. Allen-Jenkins if you would a like a personal copy of any portion of the policies.

Notice of Privacy Practices

I hereby acknowledge that I have read and understand the Maria Allen-Jenkins, Psy.D., PLLC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Allen-Jenkins. I am aware that I may request a copy of the Notice.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian, or Responsible Party Date

Statement of Fees

I have read and understand the Professional Fees as outlined by Maria Allen-Jenkins, Psy.D., PLLC. I hereby acknowledge that I am personally responsible for the fees charged for receiving services. I understand that insurance claims are submitted only as a service. I also understand that I must give 24 hour notice of cancellation to avoid being charged a cancellation fee for failing to attend an appointment I have made.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian, or Responsible Party Date

Consent to Treat

I have read and understand the Consent to Treatment Information and hereby give Dr. Allen-Jenkins consent to treat. I have had an opportunity to ask questions about them, and I agree to enter a professional relationship with Dr. Allen-Jenkins. I understand that there are possible side effects of therapy and that I can terminate this consent for treatment at any time. I understand the limits to confidentiality, the cancellation policy, emergency access, and matters related to insurance billing and special fees.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian, or Responsible Party Date

_____ _____
Signature of Therapist Date

Maria Allen-Jenkins, Psy.D., PLLC
4165 Westport Rd., Ste 303 · Louisville, KY 40207 · www.drmariaallenjenkins.com · (502) 709-8850

Authorization for Release of Records and Information

(Optional)

Client's Printed Name_____ Date of Birth_____

I hereby authorize Maria Allen-Jenkins, Psy.D., PLLC to **secure and/or release information** for professional use from the records of the client identified below. This authorization includes the release of psychological and/or psychiatric information which may be part of the client's medical record. It is understood that this release will include drug and alcohol information. This information is covered by Federal regulations which restrict further disclosure without additional authorization by the client.

Except for the release of information to obtain insurance coverage for costs incurred, this release authorization shall terminate 1 year from the date of signature, or may be revoked at any time upon written notification by the signatory of the client. Revocation has no effect upon action previously taken under this authorization.

Information of the agency or individual releasing and/or obtaining information under this release:

Physician's or Other Name _____

Address _____

Circle each purpose or need for disclosure:

Continuity of Care
Legal Proceedings
School Placement or Assessment
Other (explain) _____

Circle each type of information to be disclosed:

Diagnosis
Dates of Treatment
Admission History/Intake Report
Letter Confirming Attendance/Treatment
Evaluation
Treatment Plan
Other (explain) _____
Any or all of the above

Client Signature_____ Date_____

Parent/Guardian Signature_____ Date_____