Hoffmann Ψ Burchett Psychological Services, LLC
205 N. Williamsburg Drive, Suite F, Bloomington, IL 61704

Client Contact Information/Initial Intake Questionnaire
Child/Adolescent

Child's Name:_____ **Nickname:** _____ **DOB:** _____

Address: _____

Cell Phone (if applicable): _____ **Email:** _____

Name of school attending: _____ **Current Grade:** _____

Parent/Legal Guardian Name & DOB:

_____

Address:

_____

_____

Cell Phone: _____

Work Phone: _____

Occupation: _____

Current Employer: _____

Email: _____

Second Parent/Legal Guardian Name & DOB:

_____

Address:

_____

_____

Cell Phone: _____

Work Phone: _____

Occupation: _____

Current Employer: _____

Email: _____

**Unless otherwise noted all phones numbers listed will be considered acceptable for contacting you and/or leaving messages regarding treatment, appointments, and/or billing. If there is a number that you prefer we use to contact you, please note this above.

Please list names, date of birth/age, and relationships of other family members currently living in the home or siblings living outside the home:

_____

_____

_____

If you would like appointment reminders, please circle the format preferred:

HOME TEXT (_____) EMAIL (_____)

In addition to appointment reminders, you have the option to access online services in order to schedule appointments, update your insurance information, complete your biographical information, and contact your provider by secure email. If you are interested, please provide a user name below. Your temporary password will be your child's first name and year of birth.

User Name: _____

If you will be using insurance, please provide your insurance card to be copied.

Name of Insured: _____ **Insured's DOB:** _____

Insured's Relationship to child: _____ **Insured's Employer:** _____

Insurance Plan _____ **Insured's ID#** _____ **Insured's Policy Group #** _____

Insurance Plan Customer Service/Authorization Telephone # _____

Do you have a secondary insurance plan? Yes No

Name of Insured: _____ **Insured's DOB:** _____

Insurance Plan _____ **Insured's ID#** _____ **Insured's Policy Group#** _____

Other Insured's Employer: _____

Please Identify to whom, and where, you would like billing statements to be sent (if different than primary address):

_____

_____

Credit Card Information:

Please circle Credit Card type and complete the Information requested below in order to authorize payment on accounts with an outstanding balance of over 30 days:

Visa MasterCard American Express Discover

Cardholder's Name: _____

Account Number: _____ **Expiration Date (mm/yr)** _____

CVV (3 or 4 digit number): _____

Cardholder's Signature (to be kept on file): _____ **Date:** _____

Emergency Contact

Name: _____ **Relationship to client:** _____

Phone number(s): _____

Please state briefly your reason for seeking psychotherapy at this time:

_____

_____

_____

How long has this been a concern?_____

Under what conditions is it usually worse?

_____

_____

Under what conditions is it usually better?

_____

_____

What do you feel is your child's biggest need at this time? _____

What do you hope to gain by seeking assistance from this provider?

_____

_____

If you were to pick three (3) goals to work on, what would they be?

Goal 1: _____

Goal 2: _____

Goal 3: _____

Is there anything else you would like us to be aware of/feel is of significance for us to know?

_____

_____

_____

Does your child have any significant health/medical problems? Yes No

If Yes, please describe: _____

Allergies? Yes No If Yes, please describe: _____

Current Medications, including over the counter medications, vitamins or other supplements (Name/Dose/ Reason/Known Side-Effects):

_____

_____

_____

Approximate date of last physical exam: _____

Name of current physician: _____

Name of current psychiatrist (if applicable): _____

Other current health care providers (if applicable): _____

Who referred you? _____

_____ _____

Signature of person completing this form Date

All of the above information is considered confidential within the bounds outlined in the Guidelines for Psychotherapy Services and Informed Consent agreement. Thank you.