Diagnostic code________ **CoPay _________**

GENERAL INTAKE INFORMATION-CHILD

Client Name:________________________________ Today's Date:___________________

Parent/Guardian:____

Referred by:____

Date of Birth:___________________ Age:__________ Gender: M F

School:____ Grade:______________

Name & age of those Living in Household:

____

Home Address:____Zip_______

Home Phone: _________________________Cell Phone: ______________________

Work Phone:_______________________ Email:________________________________

Where would you like us to leave confidential messages?__________________________

Emergency Contact:__________________________Phone:____________________

Date of Last Physical:________________ Primary Care Physician:________________
PCP Phone__________________________ PCP Fax____________________________
Current Diagnosis, Medications, Allergies or Medical Concerns: ___________________
____

Past Counseling/Testing History:
Date Length of Service Agency and Therapist Providing Service
____
____

Briefly Describe why you are seeking counseling or testing:
____

Parent/Guardian Signature:____

Signature indicates consent for Beverly Newman to contact PCP or emergency contact in the rare case an emergency should occur.

Beverly Newman, MA, LPC-S, LSSP, RPT-S
Newman Clinical Associates/Sandlot Counseling Center www.newmanclinical.com
738 Hwy. 6 So Suite 300, Houston, TX 77079 Tel (713) 826-1381 Fax (281) 870-9009

Parent Information Form

Instructions: Please complete all sections to the best of your ability. Should you need more space, feel free to write on the back or use extra paper. This information will be kept confidential and released only to those persons you specifically request or provide consent.

Child's Name: ____Birthdate:_________________________ Sex:____________
Address: ____Phone: ______________________________
Parent(s)/Guardian(s): ____
Information furnished by: _____________________________________(child's __________________________) School Year:_______
Teacher's Name(s): ____Grade: ____________
Medicaid eligible: [ ] Yes [ ] No

Educational History

Place a check next to any educational problem your child has experienced:

[ ] Has difficulty reading
[ ] Has difficulty with math
[ ] Has difficulty with spelling
[ ] Has difficulty with writing
[ ] Has difficulty with other subjects (Please list) ______
____
[ ] Has difficulty paying attention
[ ] Has difficulty sitting still
[ ] Has difficulty waiting turn
[ ] Has difficulty respecting others' rights
[ ] Has difficulty remembering things
[ ] Loses important items/papers
[ ] Has difficulty getting along with teacher
[ ] Has difficulty getting along with children
[ ] Dislikes School
[ ] Has difficulty following instructions
[ ] Has difficulty completing tasks
[ ] Has difficulty controlling impulses
[ ] Speech is difficult for others to understand

Did your child attend preschool prior to entering kindergarten?____
Were there any problems?____
At what age did your child begin Kindergarten?________________
Has your child ever been held back in a grade? No Yes (Describe)____
Has your child ever been evaluate or tested for any suspected difficulty? No Yes (Describe)_________________________________
Has your child's school performance become poorer recently? No Yes (Describe)____
Has your child missed a lot of school? No Yes (Describe)____
Is child attending school? Yes No Is child expected to Pass Fail this year?
What special services, if any, is the child receiving in school? In what subjects and for how many hours per day?_________________
____
Is the child presently receiving counseling in the school? Yes No If yes, from whom?_________________Phone #______________
May we contact him/her? Yes No
List below, beginning with nursery school, and account for each year:

School District/Agency	Years	Grades	Name of School	Retained, Placed, or Promoted

Developmental History

Pregnancy

This child was pregnancy number _________ Mother's age at delivery _________
Did mother take medication to assist fertilization? No Yes (specify): ____
Did any of the following problems exist during this pregnancy? (please check)

[ ] unusual swelling
[ ] abnormal blood pressure High? _______ Low? _______
[ ] infections
[ ] premature labor
[ ] unusual weight gain or loss? How much? _____________
[ ] measles
[ ] bleeding/spotting? Which month? ___________________

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During pregnancy, did mother receive prenatal care? ____
During pregnancy, did mother smoke? _____ (Specify how many cigarettes each day): _____________________
During pregnancy, did mother drink alcoholic beverages? _____ (Specify what/how much daily) _____________
During which trimester was the alcohol consumed? 1st 2nd 3rd
Was there any time when 5 or more drinks were consumed at one time during pregnancy? No Yes
During pregnancy, did mother take medication/drugs (including prescription, over-the-counter, and recreational? Specify:

____
Was the child born near expected delivery date? No Yes Weeks early? __________Weeks Late? ___________
Was labor between three to eighteen hours? Yes No How long? ________
Was delivery normal? Yes No (Specify any complications) ____
How much did the baby weigh at birth? __________
Was child healthy **at** birth? Yes No (Specify) ____
Was child healthy **after** birth? Yes No (specify) ____
Please comment on other significant factors relating to child's birth: ____

Infancy

[ ] Extremely active baby/child? [ ] Extremely quiet baby/child? [ ] Disliked being held?
[ ] Excessive crying or colic? [ ] Feeding problems? [ ] Sleeping problems?
As an infant, was child different in any way from siblings? No Yes (Specify) ____

First Years

Approximately at what age did your child begin saying words? ____
Approximately at what age did your child begin talking in short sentences? ____
Approximately at what age did your child begin walking?____
During your child's first years, did he/she show any of the following behaviors?

[ ] Did not enjoy cuddling
[ ] Excessive restlessness
[ ] Constantly into everything
[ ] Was not calmed by being held
[ ] Poor sleep patterns
[ ] Excessive accidents
[ ] frequent head banging
[ ] Feeding problems
[ ] Excessive screaming
[ ] Biting self or others
[ ] Prolonged fixed staring
[ ] Destructiveness
[ ] Nervousness
[ ] Easily upset
[ ] Irritability
[ ] Problems adjusting to change
[ ] Problems with other children
[ ] Social fear/withdrawal
[ ] Refusal/reluctance to speak
[ ] Lack of response when spoken to
[ ] Night terrors
[ ] late in beginning to speak
[ ] Repeated noises or facial grimace

Child's Medical/Health History Child's Physician:____

Has your child ever had any of the following:

[ ] Frequent ear aches? [ ] Tubes places in ears? What age?__________________________
[ ] Surgery? Type:____ What age?__________________________
[ ] Serious accident/Injury? Type:_______________________________________What age?__________________________
[ ] Hospitalization? Specify:____ What age?__________________________
[ ]Unusually high fever? Specify:____What age?__________________________
[ ]Seizures/Convulsions? Specify:____What age?__________________________
[ ]Allergies? Specify:____ What age?__________________________
[ ]Asthma? Specify:____What age?__________________________
[ ]Respiratory infections? Specify:____What age?__________________________
[ ]Frequent sore throats? Specify:____What age?__________________________
[ ]Anemia? Specify:____What age?__________________________
[ ]Prolonged medications? Specify:_______________________________________What age?__________________________

Family Information

Father's Education: Highest level completed ____________________Occupation _________________________Age: _____
Mother's Education: Highest level completed ____________________Occupation _________________________Age: _____

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Parent Information Form

Who in your family has had learning problems? ____
Who in your family has had attention problems? ____
Who in your family has had behavior, emotional or mood problems? ______________________________
If YES to any of the above, explain ____
____
Do both parents live in child's home? _____ If not, with whom does the child live? ________________
Is the child adopted? _____ Placed in home at what age? _____ Prior foster home placement(s)? ______
Siblings and ages: ____
Are there any other adults or children living in the home? _______ Who? _________________________
Their ages: ____
Has there ever been a separation within the family unit? _______ If YES, explain __________________
____
What languages are spoken at home?____
How many homes has the child lived in?____
With whom does the child share a bedroom and/or bed?_______________________________________
Who cares for the child during the day?____
If remarried, how old was your child and his/her reactions when the stepparent entered the family? ___________
Have important changes occurred within the family since the child started school? _______ If YES, explain:___________
____
Has any specific family incident occurred that might upset your child? _______ If YES, explain: ___________
____
Please describe your child's behavior at home (Ex: generally well behaved; argumentative; etc.) ___________
____
Describe your child's behavior during play activities alone or in a group. ___________________________
____
What are your child's **favorite** activities? ____
What activities are **least** liked by your child? ____
What do **you** enjoy doing with your child? ____
What chores does your child do at home? ____
What time does your child usually go to bed on weekdays? ___________On weekends? ________________
Describe any recent change in his/her behavior. ____
____
Describe how he/she gets along with other family members, neighbors, and playmates. _______________
____
Describe disciplinary techniques that are used with your child at home (Ex: time-out; extra chores; rewards for good behavior; spanking). ____
Which disciplinary techniques are usually effective with your child? _____________________________
With what type(s) of problems? ____
Which disciplinary techniques are not effective with your child? _________________________________
With what type(s) of problems?____
Describe your child's reaction to discipline: ____
Has your child mentioned problems with school? ____
How does he/she feel about the problems?____
Has your child mentioned problems with friend/classmates?_____________________________________
How does he/she feel about the problems?____
Do you think your child may have an emotional problem?____
Past consultations: Sources of help sought in the past (Psychologists, psychiatrists, etc)_______________
Is there any other information you think may help us in working with your child?____________________
____

I am delighted that you chose me as your counselor and I want to get to know you!!! Please answer the following questions and return this paper back to me!

WHO ARE YOU?

My name is ____

The date today_____________________ My birthday __________________

I came here today____

____

Fun for me____

____

____

I worry about____

____

____

Growing up in my family____

____

Outside school____

When I grow up I want to be _______________________________________

I think it would be fun to learn more about ______________________________

____

My pets are ____

____

My favorite place is ____

My favorite food is ____

I am best at ____

____

When alone, what I most like to do is____________________________________

____

If I could change one thing____

____

If I ever write a book, it would be about__________________________________

____

I get mad____

____

The nicest thing that has ever happened to me_____________________________

____

Something I'd like my teacher to know about me is__________________________

____

The best thing my teacher can say to me is_______________________________

____

I feel proudest of myself when____

____

What I like to do on the weekends most is_________________________________

____

The best thing my parent can do for me is_________________________________

____

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About Your Child's Symptoms

Please mark all of the items that apply to your child. Feel free to add any others at the end under, "Any other characteristics."

- o Accident Prone
- o Affectionate
- o Aggressive
- o Any other characteristics:
- o Argues
- o Assaults
- o Bathroom language
- o Bigoted
- o Bossy to others
- o Breaks rules
- o Breaks the law
- o Bullied by others
- o Bullies others
- o Cheats
- o Clowns around
- o Competition
- o Complains
- o Complaints of feeling sick
- o Compliant
- o Concern for others
- o Conflicts at home
- o Conflicts at school
- o Conflicts with friends
- o Conflicts with police
- o Cries easily
- o Cruel to animals
- o Dares others
- o Dawdles
- o Daydreams
- o Defiant
- o Dependent
- o Destructive
- o Developmental delays
- o Difficulties
- o Difficulties with parent's partner
- o Disobedient
- o Disrupts family activities
- o Distractible
- o Dropping out of school
- o Drug or alcohol use
- o Drug sales
- o Eating issues
- o Failure in school
- o Fantasy life
- o Fearful
- o Feelings are easily hurt

____

- o Fidgety
- o Fighting

____

- o Finger sucking
- o Fire setting

____

- o Friendly
- o Hair chewing
- o Head banging
- o Hitting
- o Hostile
- o Hyperactive
- o Hypochondriac
- o Imaginary playmates
- o Immature
- o Inappropriate sexual behaviors
- o Inattentive
- o Independent
- o Inflicts pain on other
- o Insults others
- o Interrupts
- o Intimidated by others
- o Intolerant
- o Irritability
- o Isolates
- o Lacks organization
- o Lacks respect for authority
- o Learning disability
- o Legal difficulties
- o Lethargic
- o Likes to be alone
- o Loss of friends
- o Low frustration of tolerance
- o Lying
- o Manipulates
- o Masturbation
- o Mental retardation
- o Moody
- o Mute, refuses to speak
- o Nail biting
- o Name calling
- o Needs for high degree of supervision
- o Negativism
- o Nervous
- o New School
- o Nightmares
- o Noisy
- o Noncompliant
- o Obedient
- o Obesity
- o Only younger playmates
- o Oppositional
- o Out –of-seat behaviors
- o Outgoing
- o Outgoing
- o Overactive
- o Picks on others
- o Poor concentration
- o Pouts
- o Prejudiced
- o Procrastinates
- o Provokes others
- o Rages
- o Recent move
- o Refuses
- o Relationships with friends
- o Relationships with siblings
- o Relationships with teachers
- o Resists
- o Responsible
- o Restless
- o Rocking or other repetitive movements
- o Runs away
- o Sad
- o School avoiding
- o Self-harming behavior
- o Sexual preoccupation
- o Sexually active
- o Shy
- o Slow-moving
- o Slow-responding
- o Smart-alecky
- o Smoking
- o Social
- o Speech
- o Stealing
- o Stubborn
- o Suicide talk or attempt
- o Swearing
- o Talks back
- o Talks out
- o Teased
- o Teases others
- o Temper tantrums
- o Threatens
- o Thumb sucking
- o Tics-movements or noises
- o Timid
- o Truancy
- o Uncooperative
- o Uncoordinated
- o Under-active
- o Unhappy
- o Unprepared
- o Vandalism
- o Violent
- o Wastes time
- o Wetting/soiling of bed/clothes
- o Withdrawals
- o Work problems
- o Yells
- o Any Other Characteristics:

____
____
____
____
____

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Personal/Parental Issues Possibly Effecting Child

Please mark all of the items below that currently apply, and feel free to add any others at the bottom under "Other Concerns." You may add a note or details in the space next to the concerns checked.

- ☐ Abuse-emotional
- ☐ Abuse-neglect
- ☐ Abuse-physical
- ☐ Abuse-sexual
- ☐ Aggression
- ☐ Anger
- ☐ Anxiety
- ☐ Arguing
- ☐ Attention Problems
- ☐ Career concerns
- ☐ Childhood issues (your own)
- ☐ Children-care
- ☐ Children custody
- ☐ Children-management
- ☐ Choices I have made
- ☐ Codependence
- ☐ Compulsions
- ☐ Compulsive spending
- ☐ Concentration problems
- ☐ Confusion
- ☐ Crying
- ☐ Deaths
- ☐ Debt
- ☐ Decision making
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression
- ☐ Distractibility
- ☐ Divorce
- ☐ Drug abuse-over the counter medications
- ☐ Drug abuse-prescription medications
- ☐ Drug abuse-street drugs
- ☐ Drug abuse-alcohol
- ☐ Eating-poor appetite
- ☐ Eating-making myself vomit
- ☐ Eating-overeating
- ☐ Eating-under-eating
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue
- ☐ Fears
- ☐ Financial troubles
- ☐ Friendship problems
- ☐ Gambling
- ☐ Goals not being met
- ☐ Grieving
- ☐ Guilt
- ☐ Headaches, pains
- ☐ Health
- ☐ Hostility
- ☐ Impulsive spending
- ☐ Impulsiveness
- ☐ Indecision
- ☐ Inferiority feelings
- ☐ Inhibitions
- ☐ Interpersonal conflicts
- ☐ Irresponsibility
- ☐ Irritability
- ☐ Judgment problems
- ☐ Laziness
- ☐ Legal matters
- ☐ Loneliness
- ☐ Loss of control
- ☐ Losses
- ☐ Low energy
- ☐ Low frustration tolerance
- ☐ Low income
- ☐ Low mood
- ☐ Marital coldness
- ☐ Marital conflict
- ☐ Marital distance
- ☐ Marital infidelity/affairs
- ☐ Medical concerns
- ☐ Memory problems
- ☐ Menopause
- ☐ Menstrual problems
- ☐ Mixed feelings
- ☐ Mood swing
- ☐ Motivation
- ☐ Mourning
- ☐ Obsessions
- ☐ Outbursts
- ☐ Oversensitive to criticism
- ☐ Oversensitive to rejection
- ☐ Panic or anxiety attacks
- ☐ Parenting
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Phobias
- ☐ Physical problems
- ☐ PMS
- ☐ Poor self-care
- ☐ Procrastination
- ☐ Relationship problems
- ☐ Relaxation
- ☐ Re-marriage
- ☐ Risk-taking
- ☐ Sadness
- ☐ School problems
- ☐ Self abuse-burning
- ☐ Self abuse-cutting
- ☐ Self abuse-other
- ☐ Self abuse-scratching
- ☐ Self-centeredness
- ☐ Self-control
- ☐ Self-esteem
- ☐ Self-neglect
- ☐ Separation
- ☐ Sexual conflicts
- ☐ Sexual desire differences
- ☐ Sexual dysfunctions
- ☐ Sexual-other issues
- ☐ Shyness
- ☐ Sleep-insomnia
- ☐ Sleep-nightmares
- ☐ Sleep-too little
- ☐ Sleep-too much
- ☐ Step parenting
- ☐ Stress
- ☐ Stress management
- ☐ Suicidal thoughts
- ☐ Suspiciousness
- ☐ Temper problems
- ☐ Tension/stress
- ☐ Thought disorganization
- ☐ Threats of violence
- ☐ Tiredness
- ☐ Tobacco use
- ☐ Violence
- ☐ Work problems
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Employment problems
- ☐ Employment-lack of
- ☐ Employment-overdoing
- ☐ Employment-termination
- ☐ Other Concerns:

____
____
____
____
____
____
____

Return via email: Proclaims@ProclaimsMB.com

FAX: 1-866-431-8697

Client Insurance Information Verification Request Form

Provider Name: Beverly Newman, MA, LPC-S, LSSP, NCC, RPT-S
Newman Clinical Associates/Sandlot Counseling Center 2014©
Office Location: 738 Hwy 6 South, Ste. 300, Houston, TX 77077
For appointment: 713-826-1381

Client's Name____

Clients Date of Birth _________________________

Home Address____

City___________________________________ Zip ______________________________

Insured's Name ____

Insured's Date of Birth __________________Social Security # _________________________

Insured's Email Address ____

Insured's phone/cell ____

Insurance Company Name ____

Phone number to check benefits for Mental Health ________________________________

ID # ________________________________Group # _______________________

Employee Assistance Program (EAP) Benefits Provider________________________________

EAP Phone Number to check benefits for Mental Health________________________________

// Beverly Newman, MA, LPC, NC C, LS SP, RPT

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To be Completed by Divorced or Divorcing Parent(s) Seeking Treatment for Child

Custody Dispute Contract

Child's Name:____ **Date of Birth:**_____________________

The purpose of this contract is to obtain written agreement that the psychotherapist, Beverly J. Newman, will not be asked to participate in litigation regarding any custody or access disputes. If Beverly Newman is asked to participate in any litigation, Beverly Newman's neutral role with the family may be compromised. This is likely to jeopardize any serious progress that may have been made in therapy, to hinder the likelihood of further progress, and possibly to limit the client's willingness to seek help from a psychotherapist at any later time in his/her life. In order to prevent these problems or other potential problems, it is crucial that Beverly Newman, the parents, and the client have every reassurance that there will be absolutely no involvement on Beverly Newman's part in any current or future litigation between parents. This is best accomplished by both parents signing this agreement:

We wish to enlist Beverly J. Newman, MA, LPC, NCC, LSSP, RPT in treatment of our child,

____

We understand that such treatment will be compromised if information revealed therein is brought to the attention of the court in the course of a custody dispute. Accordingly, we mutually pledge that we will neither individually nor jointly involve Beverly Newman in any litigation whatsoever. We will neither request nor require Beverly Newman to turn over her notes to the court or any attorneys or other personnel involved an any custody dispute process. If the services of a mental health professional are desired for court purposes, the services of a person other than Beverly Newman must be enlisted.

____

Signature of Parent Date

Printed name of Parent ____

____

Signature of Parent Date

Printed Name of Parent ____

____

Signature of Witness Date

Printed Name of Witness ____

Please attach a copy of your Divorce Decree from both parents