

Lucy Heggenstaller, M.S.W., L.C.S.W., B.C.D.
3 Hospital Drive, Suite 308
Lewisburg, PA 17837

CHILD INTAKE FORM

Child's first name _____ MI _____ Child's last name _____

Child's Birthday DD/MM/YY _____ Child's SS number _____ Child's Gender M F

Name of Father _____ Name of Mother _____

Father's address _____ Mother's address _____

Father's home phone _____ Mother's home phone _____

Father's work phone _____ Mother's work phone _____

Father's cell phone _____ Mother's cell phone _____

Emergency contact _____ Emergency number/s _____

Relationship of contact _____

Name of Pediatrician _____ Phone # of Pediatrician _____

PARENTAL CONSENT TO TREATMENT

I (patient's father) hereby request therapeutic services from Lucy Heggenstaller, M.S.W., L.C.S.W., B.C.D. on behalf of myself and my minor child named above. I acknowledge and understand that no guarantee or assurance has been made as to the outcome/results that may be obtained from these services.

Signature of father: _____ Date: _____

I (patient's mother) hereby request therapeutic services from Lucy Heggenstaller, M.S.W., L.C.S.W., B.C.D. on behalf of myself and my minor child named above. I acknowledge and understand that no guarantee or assurance has been made as to the outcome/results that may be obtained from these services.

Signature of mother _____ Date: _____

Custody Information: _____

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Please describe the concerns that brought you and your child into counseling. _____

What behavioral goals do you have for your child, yourself or your family? _____

Have you and/or your child received any counseling or medical treatment for behavioral problems or emotional issues in the past? If so, with whom? What was your child treated for? Was it helpful?

Is your child in treatment for any physical illnesses or injuries at this time? If so, please describe.

Is your child taking any medications at this time? If so, please list the medications, what each medication treats, and whether the medication seems to be helpful. _____

Please list significant events in your child's medical history, such as prenatal problems, birth trauma, past surgeries, serious accidents, head injuries, significant illnesses, etc. _____

Please complete the CHILD SYMPTOM SCREENING FORM. Thank you for your patience!