# Mark N Lazich, MS, LMHC

**1101 Harris Avenue, Suite 26, Bellingham, WA 98225**
**PH: 360.306.5975**

## CHILD AND FAMILY INTAKE FORM

**Please complete all pages of form.**

Today's Date:_____

Child's Full Name:_____ Social Security#: _____
Date of Birth: _____ Gender: ☐ MALE ☐ FEMALE
Referred by: _____ Primary Care Physician: _____

Child lives with: Both☐ Mother☐ Father ☐ther: _____☐
Mother's Name: _____ Social Security#: _____
Father's Name: _____ Social Security#: _____

Child's Address: _____
_____

Home Phone: _____ day☐ evening☐ OK to leave msg? YES NO
Work Phone: _____ day evening OK to leave msg? YES NO
Cell Phone: _____ day☐ even☐g OK to leave msg? YES NO
☐ ☐

## PRIMARY INSURANCE INFORMATION

**(information found on insurance card)**

Insurance Company: _____ Phone#: _____
Insurance Company Address: _____
Subscriber's Name: _____ Relationship to client: _____
Subscriber's Address: _____
ID#: _____ Group/Plan #: _____

## SECONDARY INSURANCE INFORMATION

**(information found on insurance card)**

Insurance Company: _____ Phone#: _____
Insurance Company Address: _____
Subscriber's Name: _____ Relationship to client: _____
Subscriber's Address: _____
ID#: _____ Group/Plan #: _____

## COUNSELOR'S NOTES (for office use only)

| Date | Dx code | Dx | Provider Signature |
|---|---|---|---|
| | | | |
| | | | |

# CHILD'S MEDICAL HISTORY

How is your child's general health? Excellent ☐ood Fair ☐Poor ☐ ☐

Briefly describe your primary concerns and why you have brought your child to the office:

_____

_____

When was your child's last comprehensive medical evaluation? _____

Has your child ever been hospitalized for psychological reasons?
Yes ☐ No ☐
If yes, when and where? _____

Please check whether your child currently has, or has ever had any of the following:

__drug/alcohol abuse
__running away
__disturbing thoughts
__memory problems
__irritability
__bowel problems
__suicidal ideations/attempts
__sexual concerns
__chronic illnesses
__phobias:_____
__physical abuse or neglect
__racing thoughts
__broken bones
__problems with coordination
__sleeping problems
__frequent headaches
__lack of interest
__low self-esteem
__emotional abuse
__irregular heartbeat
__feelings of hopelessness
__difficulty managing anger
__family/relationship issues
__hormone disorder
__panic attacks
__frequent stomachaches
__school/work difficulties
__frequent or uncontrolled crying
__changes in appetite
__epilepsy or seizures
__sexual abuse
__speech problems
__hearing problems
__visual problems
__homicidal thoughts
__asthma
__communication problems
__difficulty concentrating
__serious infection
__feelings or paranoia
__blood pressure concerns
__self-destructive or self-injurious behavior
__flashbacks
__ulcers
__depression
__confusion
__stress
__bedwetting
__weight loss
__head trauma
__mood swings
__anxiety
__allergies

__Other physical or emotional issues (please describe):

_____

_____

Is your child currently taking medication? ☐ Yes ☐ No
Medication: _____ Dosage: _____ Date Started: _____
Medication: _____ Dosage: _____ Date Started: _____
Medication: _____ Dosage: _____ Date Started: _____

List any serious illnesses for which the child required hospitalization or surgical operation:

| Illness | Year | Doctor | Hospital |
|---|---|---|---|
| | | | |
| | | | |

Has your child ever received psychological, substance abuse, or psychiatric services?

| Service | Year | Doctor | Issue at Time |
|---|---|---|---|
| | | | |
| | | | |

## FAMILY SITUATION

Relationship/Marital Status of parents: ☐ Single ☐ Involved ☐ Engaged ☐ Cohabitating
☐ Remarried ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Names and ages of other adults & children residing in the home:

| Name | Age | Relationship to Client |
|---|---|---|
| | | |
| | | |
| | | |

**Mother's-**

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

**Father's-**

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

Are there any family members experiencing significant medical problems or substance abuse?
**(Please indicate relationship to child)**:

Medical Problems-
Past: _____
Present: _____

Alcohol Use-
Past: _____
Present: _____

Drug Use-
Past: _____
Present: _____

Tobacco Use-
Past: _____
Present: _____

Caffeine Use-
Past: _____
Present: _____

Have you had previous counseling? ☐ Yes ☐ No

If yes, with whom? _____ When? _____

Would it help to contact your previous counselor(s)? ☐ Yes ☐ No

## GOALS FOR THERAPY

What are the goals and outcomes you would like to achieve for your self/child with therapy?

_____

_____

_____