Julie Maccarin, PhD, OT/L

**CHILD PSYCHOLOGY MARIN**

45 San Clemente Drive, Suite D220, Corte Madera, California 94925 (415) 785-3700

**INTAKE INFORMATION**

Child’s Name Birth Date

Primary Address Current Age

City State \_\_\_\_\_\_\_\_ Zip

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Telephone (Home) Child’s Social Security Number

Name of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Occupation (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Business Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Occupation (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Business Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others living in home with child, (ages and relationship to child) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please briefly describe your concerns about your child:

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How do you feel these difficulties developed?

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Marital Status of Parents (Married, Divorced, Separated, Never Married, Other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If parents are separated or divorced, please complete the following:**

Joint or Shared Custody? Y N

How old was your child when parents separated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ divorced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are both parents aware of and in agreement about bringing your child in for this treatment? YES NO

If no, please explain. (Use back of paper if needed) \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are both parents willing to participate in this child’s therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INTAKE INFORMATION CONTINUED** (Please use back of paper as needed)

Have there been any significant stressors for your family in recent years: (losses, births, deaths, separation or divorce, significant illnesses, moves, hospitalizations, financial problems, etc.)? Please describe.

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Has your child experienced any trauma? If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child previously received counseling or therapy? If so, when and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DEVELOPMENTAL HISTORY**

Please describe your child’s general health:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Approximately how old was your child when he/she

Crawled \_\_\_\_\_\_\_ Walked \_\_\_\_\_\_\_ Began speaking \_\_\_\_\_\_\_ Able to speak in full sentences \_\_\_\_\_\_\_

Toilet trained \_\_\_\_\_\_\_ Slept through the night \_\_\_\_\_\_\_

Does your child currently have night terrors or nightmares, and if so, how often?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child currently have other sleep problems? Please describe.

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Does your child currently have eating concerns/food issues and/or weight problems? Please describe.

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Does your child have any learning or medical problems? If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child previously received occupational, speech or physical therapy? If so, when, where and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child been immunized? \_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_\_ No

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**SOCIAL/EMOTIONAL DEVELOPMENT**

Would you describe your child as (circle all that apply):

Withdrawn Hyperactive Disruptive Anxious Frightened

Depressed Lonely Sad Stubborn Inattentive

Angry Defiant Friendly Playful Happy

Aggressive Bullied Self deprecating Irritable Impulsive

Are you concerned that your child has a problem with (circle all that apply):

Family grief/loss Regulating emotions Dealing with a traumatic event Phobias

Making friends Getting along with peers Getting along with siblings

Transitions Coping skills Processing/following instructions

Academic skills Stealing Lying Gender identity

Being safe Self esteem Panic attacks Sexual behavior

Somaticizing (having stomach aches or other physical problems for which there is no medical explanation)

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark which of the descriptions in each row is more like your child (Add notes on back, if needed):

Calm, takes things in stride High strung, over reacts, worries

Cheerful, always looks on the bright side Serious, somber most of the time

Steady, stable mood Mood fluctuates unpredictably

Low keyed, laid back High intensity, overwhelms people, loud

Tends to likes new people and situations Initially withdrawn, dislikes new situations, shy

Generally seems to feel safe and secure Frequently worries or feels anxious

Fears are few and far between Many fears or frequent fears

Flexible, handles changes and transitions easily Resistant to change, difficulty with transitions

Can be energetic but also quiet for periods of time Rarely sits still, always on the go

Focused, usually concentrates well Distracted easily, forgetful, disorganized

Can persist towards goals, but can accept “no” Stubborn, argumentative

Very regular rhythms (eating, sleeping, etc.) Irregular or unpredictable rhythms (eating, sleeping, etc.)

Careful, takes his/her time on things Impulsive, acts without thinking

Slow to anger Quick to anger

Handles anger appropriately for age When angry, becomes aggressive (hits, bites, throws, etc)

General behavior is usually appropriate  Often silly, goofy or inappropriate

When upset, responds to efforts to calm him/her When upset, parent’s efforts to calm child increase upset

Can calm down when upset in reasonable time Remains upset, sad, mad, etc, for a prolonged time

After upset, child is able to move on After upset, child feels excessively guilty or blaming

Normally careful with own body Engages in risky/dangerous activities

Has good self esteem Has low self esteem

Eats normally Eats excessively or eats very little

Falls asleep shortly at bedtime, stays asleep Can’t fall asleep and/or wakes during the night

Wakes in morning and rises in short time Difficulty waking and/or rising in the morning

Allows others to be in control Wants to be in control all of the time

Learns from experience Does not seem to learn from experience

Socially adept Socially awkward, doesn’t seem to read social cues

Not bothered by much Very fussy about one or more types of sensory stimuli circle which one(s): sounds, smells, touch, food, other

Is there a family history of the following:

Yes No Which family member or members?

Learning Problems \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADD/ADHD \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Autism spectrum \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Addiction \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other psychiatric conditions \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious medical problem \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genetic abnormality \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN INFORMATION**

My child’s physician is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do \_\_\_\_\_\_\_\_ do not \_\_\_\_\_\_\_\_ give Dr. Maccarin permission to share basic information about my child’s treatment with his/her physician. (Please initial your choice)

**MEDICATION**

Is your child currently taking any medication(s) for any condition? If so, please describe (type, dosage, frequency, prescribing physician, and condition): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child taken medication in the past for emotional or behavior conditions? If so, please describe (type, dosage, frequency, prescribing physician, and condition): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: Please advise me any time there is a change in the medications your child is taking.

**REFERRAL INFORMATION**

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I contact this person to thank them for referring you here? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Would you like me to share information about your child’s treatment with this person?

Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

**PAYMENT INFORMATION:**

Person Responsible for Payment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have out of network coverage for mental health through your insurance company and you would like me to provide you with a monthly Superbill for submission to your insurance company, please initial here: Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

SIGNATURE:

My signature below indicates that the above information is correct and accurate to the best of my knowledge. I permit copies of this authorization to be used in place of the original. I understand that I have the right to revoke this authorization by presenting written notification to Dr. Julie Maccarin.

*This authorization is valid for the duration of treatment and until any and all payment issues are resolved*.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name Signature of Parent/Guardian Date

**Acknowledgement Of Receipt Of Hippa Compliant Notice Of Privacy Practices And Consent**

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), a Notice of Privacy Practices is included on the website ChildPsychologyMarin.com, which details how health and clinical information may be usedfor the purposes of Treatment, Payment, Health Care Operations and other purposes. As more fully explained in that document, you may have the right to request restrictions on how I use and disclose your protected health information. I are not required to agree to requests, however, if I do, that request does not include use of information that may be needed to provide emergency treatment to you. I reserve the right to change my privacy practices in accordance with the HIPAA Privacy Rules; the terms contained in the Notice Of Privacy Practices may change also. If this occurs, those changes will be posted on the above named website, indicating the effective date. A copy of the new Notice of Privacy Practices will be provided to you at your request.

My signature below indicates that I have received the Notice Of Privacy Practices of Child Therapy Marin. I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that the information has already been used or disclosed in reliance on this consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name Signature of Parent/Guardian Date