WATER'S EDGE
PSYCHOTHERAPY & WELLNESS CENTER

47 Maple Street, Suite 303
Burlington VT 05401

REGISTRATION FORM

Client Name: ____ Date of Birth: ______/______/______ M/F

Address: ____ Social Security Number: ______-_____-________

(Street)

Address:____ Email Address______________________________

(City/State/Zip)

Home Phone: (______)________-___________ Cell Phone: (______)________-___________

Work Phone: (______)________-___________ Can we leave a message at any of these numbers? H C W (circle)

Primary Care Physician: _________________________________ Phone number: (______)_______-___________

Name of Guardian/Parent (if applicable): _________________________________

Emergency contact: _________________________________ Phone: (___) ______ - ________

How did you hear about our practice? ____

FIRST INSURANCE INFORMATION

Plan Name: ______________________________________ I.D. Number: __________________________________

Co-pay amount $_________ HSA? yes/no (circle one) High-deductible? yes/no (circle one)

Address: ____ Group Number: _________________________

Policy Holder: ____ Effective Date: __________________________

Policy Holder's Social Security #: _______-______-_________ Policy Holder's Date of Birth: ______/______/______

SECOND INSURANCE INFORMATION

Plan Name: ______________________________________ I.D. Number: _________________________________

Policy Holder: ______________________________ Co-pay amount $_______ Group Number: ______________

Policy Holder's Social Security #: ______-______-_________ _ Policy Holder's Date of Birth: ______/______/______

PERSON RESPONSIBLE FOR BILL

Guarantor Name: ___________________________________ Date of Birth: ______/______/_____

Relationship to Client: (check one): ( ) self, ( ) spouse, or ( ) parent/guardian Phone Number: (___) ______________

Address (if different from client): ____

(Street) (City/State/Zip)

Signature: ____

PERSON(S) WHO HAVE LEGAL CUSTODY

Name(s)____

Signature: ____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Water's Edge Psychotherapy. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: ____ Date: ______/______/______

Therapist__________________________ DX:____________________ 1st Date of Service: ______/______/______

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Child Intake Form

________________ ____ ________________________
Date Filled out by Relationship to Child

Child's full name_______________________________ Date of Birth: ____/____/____ Age________

Child's Address____
(Street) (City) (State) (Zip)

Health Insurance for Child: ________________________________ I.D. Number ______________

Policy Holder____________________ SS: _____-_____-______ DOB _____/_____/_____

Co-pay amount $________ HSA? yes/no (circle one) High-deductible? yes/no (circle one)

Person(s) with legal custody of child

( ) Birth Parent ( ) Adoptive Parent ( ) Step Parent ( ) Foster Parent
Name ____
Address (if different from child's) ______________________________________
Age________ Education________________________ Religion__________________
Place of Work________________ Type of Work________________ Work days/hours ______
Previously married ( ) yes ( ) no ______________________________________
Contact Numbers (H) ______________ (W) ______________ (Other) ______________

( ) Birth Parent ( ) Adoptive Parent ( ) Step Parent ( ) Foster Parent
Name ____
Address (if different from child's) ______________________________________
Age________ Education________________________ Religion__________________
Place of Work________________ Type of Work________________ Work days/hours ______
Previously married ( ) yes ( ) no ______________________________________
Contact Numbers (H) ______________ (W) ______________ (Other) ______________

Child's birth parents if not listed above ______________________________________
Reason for not living with child ____
____

Adults & children living in child's home. If not listed above:

Name	Age	Sex	Relationship to child (step, foster, adoptive unrelated, etc…)

Child's full or half brothers and sisters NOT living in child's home:

Name	Age	Sex	Living Where?

Name of Child____________________________________ Date of Birth: ______/______/______

What concerns you about your child?____
____
____
____
____

How long has this difficulty existed? ____
____
____

Why do you think your child is having problems now?____
____
____
____

Describe your child's strengths____
____
____
____

Previous Therapy________________________________ Medications________________________________

If yes, where & when____
____

Child's Medical History

	YES	NO	Describe
Medical problems during pregnancy?			
Medications during pregnancy?			
Did either parent drink alcohol or use drugs during pregnancy?			
Other problems during pregnancy? (marital, job, money, living conditions)			
Birth weight:			
Was child born prematurely?			How premature?
Problems with newborn period or infancy? (birth defects, yellow jaundice, seizures, infections, injuries, feeding problems)			

Describe all sever illnesses, accidents, operations, handicaps, and repeated medical problems (such as ear infections, headaches, etc.) and the ages when they happened.

____
____
____
____

Name of Child___________________________________ Date of Birth: ______/______/______

Does the child take any medications?

Medication	Dosage	Reason	Effect	MD

Child's Pediatrician____
Address____ Phone number: (______)_______-___________
Date of last physical exam______/______/______ Outcome____
Allergies ____

Child's Developmental History

Have you noticed any problems in development? ( ) yes ( ) no Describe_______________________________
____

Were any of the following difficult or slow to develop?

	YES	NO	Describe
Walking alone			
Speaking			
Bowel/bladder training			
Staying dry at night			
Writing/Reading			
Riding bicycle			
Tying shoes			

Have there been any problems in the following areas?

	YES	NO	Describe
Discipline			
Temper or fighting			
Moods			
Relationships with others			
Sex play			
Other behaviors			

Child's School History

	YES	NO	Describe
Has your child had learning problems?			
Has your child had social problems in school?			
Is your child receiving special help at school?			
Any other school concerns?			
Does your child have an IEP or 500?			

Child's School____ Grade_____________________________
Teacher(s)

Name of Child_______________________________________ Date of Birth: ______/______/______

Child's Temperament

	YES	NO	Describe
Is your child overactive?			
Does your child have trouble paying attention?			
Does your child fluctuate from happy to sad quickly with little apparent cause?			
Does your child get frustrated easily?			
Are your child's emotional responses generally predictable?			
Does it take your child a long time to warm up to new situations or people?			
Does your child react strongly to physical pain?			
Does your child react strongly to other things?			

Family Background

	YES	NO	Describe
Neurological diseases (seizures, weakness, etc.)			
Medical diseases (Diabetics, thyroid, heart disease)			
Mental illness (Schizophrenia, bi-polar, anxiety depression)			
Development delays			
Learning problems			
Behavior problems			
Excessive use of alcohol			
Excessive use of drugs			
Trouble with the law			
Trouble holding a job			
Physical abuse			
Sexual abuse			

Family Social History

	YES	NO	Describe
Parental separation or divorce			
Family moves			
Recent deaths or losses (within last 3 years)			
Other major family changes			
Parental/marital conflicts			
Work stressors or changes			
Are your present living circumstances dissatisfying you?			
Has anyone in your family seen a psychologist, psychiatrist or other mental health worker?			
Have there been any recent changes or stresses in your living situation or family?			

Anything else you think we should know____

____