# CLIENT INTAKE SHEET for:
# SYLVA CLINICAL ASSOCIATES, P.A.

**Today's Date:**_____

**CLIENT:** _____ Sex:____M_____F
(Last Name) (First Name) (Initial) (Preferred Name)

____Single ____Married ____Widowed ____Separated ____Divorced (If Married), Spouse's Name:_____

Home Phone:_____ Cell:_____ Age:_____ Date of Birth:_____

Mailing Address:_____City_____ State_____ Zip_____

**Employer:** _____ Business Phone:_____

Occupation:_____

**Name of Who Is Responsible for Payment** _____ Relationship to Client_____

Address:_____City_____State_____Zip_____

Phone Number:_____SS#:_____Date of Birth:_____

Employer:_____Employer's Phone Number:_____

**Primary Insurance Name:** _____ **Secondary Insurance Name:** _____

Policy Number:_____ Policy Number:_____

Group Number:_____ Group Number:_____

Company Insured Through:_____ Company Insured Through:_____

**Policy Holder's Name:**_____ **Policy Holder's Name:**_____

**Policy Holder's SS#:**_____ **Policy Holder's SS#:**_____
**DOB:**_____ **DOB:**_____

**HOW DO YOU PLAN TO PAY TODAY?** _____Cash_____Check_____Credit/Debit Card (VISA/Mastercard/Discover)

**Who Referred You:**_____ **Name of Your Personal Physician:**_____

- I have read Sylva Clinical Associates Financial Policy and agree to be bound by its terms

_____ _____ _____
(Signature of Patient or Responsible Party) (Print Name) (Date)

****** CONTINUED ON BACK******

**HIPAA NOTICE OF PRIVACY PRACTICES AND CONSENT FOR TREATMENT**

*Sylva Clinical Associates, P.A.*

I give this clinic/practice my consent to use and disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality services.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more comprehensive understanding of its uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also know that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I understand the **CHARGE for my INITIAL SESSION is $195.00 and the charge for any subsequent sessions is $160.00, PLUS ADDITIONAL CHARGES for any and all psychological testing, if done, in the amount of $160.00 *PER unit* of testing**. Sylva Clinical Associates, PA, normally accepts assignments of insurance benefits. Sylva Clinical Associates, PA will look to me for full payment of my account, and I will be responsible for payment of all charges. Different co-payments are required by various group coverage plans. My co-payment is based on the insurance policy selected by me. I am responsible for and shall pay my co-pay portion of the charges for services at the time the services are provided to me. **It is recommended that I determine my co-payment or any prior authorizations required by my insurance plan for mental health benefits, before my first visit, but definitely by my second visit, by calling my benefits office or insurance company.** I have received and reviewed a copy of the Financial Policy of Sylva Clinical Associates, PA

"I consent for Sylva Clinical Associates, PA to communicate with me by mail, by phone, or by E-mail at the following address(es) and phone number(s), and I will IMMEDIATELY advise my clinician in the event of any change."

MAILING ADDRESS:_____

TELEPHONE NUMBER (s):_____

E-MAIL ADDRESS:_____

"I voluntarily agree to receive, or for my child to receive, psychological assessment, care, treatment, or services, and authorize Sylva Clinical Associates, PA, to provide such assessment, care, treatment, or services as are considered necessary and advisable."

"I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through Sylva Clinical Associates, PA, at any time."

"By signing this Notice and Consent, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me."

SIGNATURE:_____ DATE:_____

Client, Parent, or Legal Guardian

If signed by client representative, please state relationship with the client:_____

# PSYCHOLOGICAL HEALTH SURVEY

**YOUR NAME:**_____

**Please circle YES or NO to the following questions:**

**Was the child's birth normal?** YES NO
**If NO, briefly describe:**_____

**Did the child walk and talk on time?** YES NO

**Did toilet training go well?** YES NO

**Has the child been free of unusual illnesses?** YES NO
**If NO, what?**_____

**Has the child been free of allergies, asthma, headaches, and stomachaches?** YES NO
**If NO, which?**_____

**What medications is the child taking?**_____

**Has the child been free of unusual injuries?** YES NO
**If NO, what?**_____

**Is the parents' relationship with each other good?** YES NO

**Do the child's mother and father live together?** YES NO

**Does the child get along equally well with both parents?** YES NO

**Does the child get along well with children of the same age?** YES NO

**Is the child's family free of divorce, separation, death, or serious illness among family members?** YES NO
**If NO, which?**_____

**Have the child's parents, brothers, and sisters been free of psychological problems?** YES NO

**Has the child received psychological help before?** YES NO

**Does the child do schoolwork well?** YES NO
**Does the child pay attention well?** YES NO
**Does the child follow directions well?** YES NO
**Is the child's activity level high?** YES NO
**Does the child see and hear well?** YES NO
**Is the child coordinated?** YES NO
**Does the child eat well?** YES NO
**Does the child sleep well?** YES NO
**Does the child snore, wheeze, or gasp during sleep?** YES NO

**Are you or your child involved with an attorney, or other court related individuals? Or do you expect to be?** YES NO

**Do you agree not to use the therapist or the clinical record in any legal action?** YES NO

**Child lives with:**_____

**Name of Child's School:**_____ **Grade:** _____

**Name of Child's Teacher:** _____

***CONTINUED ON BACK ***

**OTHERS IN HOUSEHOLD:**

| **Name:** | **Date of Birth:** | **Relation:** | **Sex:** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Briefly describe the reason for today's visit:**

**What is your child's best quality?**

# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ Age: ____ Sex: ☐ Male ☐ Female Date:_____

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

| | | During the past **TWO (2) WEEKS,** how much (or how often) have you... | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|---|
| I. | 1. | Been bothered by stomachaches, headaches, or other aches and pains? | 0 | 1 | 2 | 3 | 4 | |
| | 2. | Worried about your health or about getting sick? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. | Been bothered by not being able to fall asleep or stay asleep, or by waking up too early? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. | Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 5. | Had less fun doing things than you used to? | 0 | 1 | 2 | 3 | 4 | |
| | 6. | Felt sad or depressed for several hours? | 0 | 1 | 2 | 3 | 4 | |
| V. & | 7. | Felt more irritated or easily annoyed than usual? | 0 | 1 | 2 | 3 | 4 | |
| VI. | 8. | Felt angry or lost your temper? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 9. | Started lots more projects than usual or done more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| | 10. | Slept less than usual but still had a lot of energy? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 11. | Felt nervous, anxious, or scared? | 0 | 1 | 2 | 3 | 4 | |
| | 12. | Not been able to stop worrying? | 0 | 1 | 2 | 3 | 4 | |
| | 13. | Not been able to do things you wanted to or should have done, because they made you feel nervous? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 14. | Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you? | 0 | 1 | 2 | 3 | 4 | |
| | 15. | Had visions when you were completely awake—that is, seen something or someone that no one else could see? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. | Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else? | 0 | 1 | 2 | 3 | 4 | |
| | 17. | Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off? | 0 | 1 | 2 | 3 | 4 | |
| | 18. | Worried a lot about things you touched being dirty or having germs or being poisoned? | 0 | 1 | 2 | 3 | 4 | |
| | 19. | Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening? | 0 | 1 | 2 | 3 | 4 | |
| | | In the past **TWO (2) WEEKS,** have you... | | | | | | |
| XI. | 20. | Had an alcoholic beverage (beer, wine, liquor, etc.)? | ☐ Yes | | | ☐ No | | |
| | 21. | Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? | ☐ Yes | | | ☐ No | | |
| | 22. | Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? | ☐ Yes | | | ☐ No | | |
| | 23. | Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? | ☐ Yes | | | ☐ No | | |
| XII. | 24. | In the last 2 weeks, have you thought about killing yourself or committing suicide? | ☐ Yes | | | ☐ No | | |
| | 25. | Have you EVER tried to kill yourself? | ☐ Yes | | | ☐ No | | |

# DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

**Child's Name:** _____ **Age:** ____ **Sex:** ❑ Male ❑ Female **Date:**_____

**Relationship with the child:** _____

**Instructions** *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

| | | During the past **TWO (2) WEEKS,** how much (or how often) has your child... | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|---|
| I. | 1. | Complained of stomachaches, headaches, or other aches and pains? | 0 | 1 | 2 | 3 | 4 | |
| | 2. | Said he/she was worried about his/her health or about getting sick? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. | Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. | Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 5. | Had less fun doing things than he/she used to? | 0 | 1 | 2 | 3 | 4 | |
| | 6. | Seemed sad or depressed for several hours? | 0 | 1 | 2 | 3 | 4 | |
| V. & VI. | 7. | Seemed more irritated or easily annoyed than usual? | 0 | 1 | 2 | 3 | 4 | |
| | 8. | Seemed angry or lost his/her temper? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 9. | Started lots more projects than usual or did more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| | 10. | Slept less than usual for him/her, but still had lots of energy? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 11. | Said he/she felt nervous, anxious, or scared? | 0 | 1 | 2 | 3 | 4 | |
| | 12. | Not been able to stop worrying? | 0 | 1 | 2 | 3 | 4 | |
| | 13. | Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 14. | Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her? | 0 | 1 | 2 | 3 | 4 | |
| | 15. | Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. | Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else? | 0 | 1 | 2 | 3 | 4 | |
| | 17. | Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off? | 0 | 1 | 2 | 3 | 4 | |
| | 18. | Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned? | 0 | 1 | 2 | 3 | 4 | |
| | 19. | Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening? | 0 | 1 | 2 | 3 | 4 | |
| | | In the past **TWO (2) WEEKS,** has your child ... | | | | | | |
| XI. | 20. | Had an alcoholic beverage (beer, wine, liquor, etc.)? | ☐ Yes | ☐ No | ☐ Don't Know | | | |
| | 21. | Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? | ☐ Yes | ☐ No | ☐ Don't Know | | | |
| | 22. | Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? | ☐ Yes | ☐ No | ☐ Don't Know | | | |
| | 23. | Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? | ☐ Yes | ☐ No | ☐ Don't Know | | | |
| XII. | 24. | In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide? | ☐ Yes | ☐ No | ☐ Don't Know | | | |
| | 25. | Has he/she EVER tried to kill himself/herself? | ☐ Yes | ☐ No | ☐ Don't Know | | | |