WELCOME TO FOUNTAINGATE
1106 COLUMBIA AVE SUITE 100, MARYSVILLE, WA 98270
Phone (360) 653-0374 Fax (360) 658-0219

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully or ask for clarification if you do not understand an item.

CHILD, ADOLESCENT, AND FAMILY

CHILDS INFORMATION:

FULL NAME: _____ Date:_____

MAILING ADDRESS: _____
(STREET OR PO BOX NUMBER)

_____
(CITY, STATE, ZIP CODE)

TELEPHONE: _____AGE: _____ BIRTHDATE:_____ SEX: ___M ___F

CHILD'S RACE/ETHNICITY: _____ BIRTHPLACE:_____

IS THE CHILD IN SCHOOL? ____IF YES, WHICH GRADE? _____ NAME OF SCHOOL: _____

PARENT/GUARDIAN'S INFORMATION:

FATHER/ GUARDIAN'S NAME: _____(PHONE IF DIFFERENT)_____

ADDRESS OF FATHER (if different):_____ _____
Street or P.O. Box

_____
City State Zip Code

RACE / ETHNICITY: _____ SSN #: _____ _____BIRTHDATE: _____

EMPLOYER: _____ WORK PHONE: _____

OCCUPATIONAL TITLE: _____FULL TIME: _____ PART TIME: _____

MOTHER/GUARDIAN'S NAME: _____(PHONE IF DIFFERENT)_____

ADDRESS OF MOTHER (if different)_____
Street or P.O. Box

_____
City State Zip Code

RACE / ETHNICITY: _____ SSN #: _____BIRTHDATE:_____

EMPLOYER: _____WORK PHONE: _____

OCCUPATIONAL TITLE: _____ FULL TIME: _____ PART TIME: _____

REFERRED BY:_____PHONE:_____

TO BE COMPLETED BY THERAPIST

Primary Diagnosis_____ **Secondary Diagnosis**_____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____

NAME OF THE INSURED: _____ INSURED'S D.O.B.: _____

INSURED'S SSN #: _____ INSURED'S GROUP #: _____

EMPLOYER: _____ AMOUNT OF CO PAY: _____

IF YOUR COUNSELING IS BEING PAID FOR THROUGH AN EMPLOYEE ASSISTANCE PROGRAM, OR ANOTHER PARTY, PLEASE LIST THE NAME OF THE PROGRAM OR PERSON, HOW MUCH THEY ARE PAYING FOR, AND HOW MANY SESSIONS ARE BEINGAUTHOURIZED.

Name:_____Amount:_____ # of Sessipons:_____

TREATMENT AGREEMENT:
PLEASE INITIAL**:**

Co payments are due at the time of service. _____

I hereby assign payment of insurance benefits directly to Fountaingate. While Fountaingate will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay. _____

It is my responsibility to contact my insurance company to obtain proper authorization if required. If I fail to do this and charges are denied I will be responsible for all charges incurred. _____

If your portion of the bill is not paid within 90 days from the last date it was incurred a letter will sent giving you 10 days to pay your account or to arrange for a payment plan. If you do not respond, you will be sent to collections_____

Our first session charge, is $200.00. Every session after that is $150.

You will be charged $150.00 for missing an appointment. _____

You will be charged $150.00 for not giving us 24 hours notice, when canceling an appointment. _____

I have read through the treatment agreement thoroughly along with the brochure about my therapist and understand and agree to abide by my financial responsibilities. I understand that information will be released to my insurance company if necessary, and any charges that my insurance company will not cover I am responsible for.

CLIENT SIGNATURE: _____ **DATE**: _____

SIGNATURE OF RESPONSIBLE PARTY_____DATE_____

To enable our staff with accurate and confidential services please complete the following:

Please be aware that email and fax transmissions arrive at a general Fountaingate site and are distributed to the individual practitioners. Confidentiality is maintained with those records, as with all records in our office.

Messages regarding appointments may be left on my answering machine. _____YES _____NO

EMAIL MAY BE USED TO COMMUNICATE WITH ME ____YES ____NO ADDRESS:_____

The following individuals may schedule and or confirm appointments.

HISTORY OF CHILD'S CURRENT PROBLEM:

DESCRIBE THE PROBLEM:
_____

_____

WHAT WOULD YOU LIKE TO SEE HAPPEN AS A RESULT OF OUR WORK TOGETHER? :

_____

WHEN DID PROBLEM BEGIN?
_____

WHAT WAS DONE TO HELP WITH THE PROBLEM?
_____

DESCRIBE THE CHILD'S STRENGTHS:_____

CHILD'S BACKGROUND INFORMATION

NAME OF PERSON GIVING INFORMATION: _____

RELATIONSHIP TO CHILD: _____

MOTHER'S INFORMATION:

PREVIOUS MARRIAGES: _____ YEARS OF CHILD'S LIFE LIVED WITH MOTHER: _____

DOES MOTHER HAVE ANY SIGNIFICANT MEDICAL PROBLEMS? _____IF YES PLEASE DESCRIBE: _____

_____

HAS MOTHER HAD ANY SERIOUS ILLNESSES, ACCIDENTS, AND SURGERIES? _____IF YES, PLEASE DESCRIBE:
_____

HAS MOTHER HAD ANY PSYCHIATRIC COUNSELING? _____ IF YES, WHEN AND WHY? _____

_____

FATHER'S INFORMATION:

PREVIOUS MARRIAGES: _____ YEARS OF CHILD'S LIFE LIVED WITH FATHER: _____

DOES FATHER HAVE ANY SIGNIFICANT MEDICAL PROBLEMS? _____ IF YES PLEASE DESCRIBE: ____

_____

HAS FATHER HAD ANY SERIOUS ILLNESSES, ACCIDENTS, AND SURGERIES? _____ IF YES PLEASE DESCRIBE:
_____

HAS FATHER HAD ANY PSYCHIATRIC COUNSELING? _____ IF YES, WHEN AND WHY?

_____

MARITAL STATUS OF PARENT / GUARDIANS:

LIVING TOGETHER SINCE: _____SEPERATED SINCE: _____ MARRIED SINCE: _____

DIVORCED SINCE: _____ WIDOWED SINCE: _____ CURRENT LIVING SITUATION: _____

CUSTODY INFORMATION:

DATES OF BEGINNING AND END OF MARRIAGE / RELATIONSHIP FROM WHICH CHILD WAS BORN:_____
_____

REASONS FOR END OF MARRIAGE / RELATIONSHIP INTO WHICH CHILD WAS BORN: _____

_____

WHO HAS LEGAL CUSTODY OF THE CHILD? _____

IS THERE A VISITATION SCHEDULE? _____

IS THE CHILD ADOPTED? _____ IF YES, EXPLAIN THE CIRCUMSTANCES: _____

_____

SCHOOL INFORMATION:

GRADE: _____ SCHOOL: _____TEACHER'S NAME: _____
SCHOOL COUNSELOR: _____ SCHOOL NURSE: _____

NUMBER OF SCHOOLS ATTENDED? _____DOES THE CHILD HAVE PROBLEMS IN SCHOOL? _____ IF YES, EXPLAIN:_____

_____

ACADEMIC PERFORMANCE: _____

IF THE CHILD HAS EVER BEEN **HELD BACK** OR PUT AHEAD IN SCHOOL EXPLAIN:
_____

_____

IF THE CHILD HAS EVER BEEN **EXPELLED** FROM SCHOOL EXPLAIN WHY AND WHEN: _____

_____

HAS THE CHILD EVER BEEN IN **SPECIAL CLASSES**? _____ IF YES, EXPLAIN WHY AND WHEN: _____

_____

LEGAL ISSUES:

HAS THE CHILD EVER BEEN **ARRESTED** OR **ON PROBATION**? _____ IF YES PLEASE EXPLAIN: _____
_____

PROBATION OFFICER: _____ PHONE: _____

HAS THE CHILD EVER RECEIVED COUNSELING BEFORE? _____ IF YES EXPLAIN: _____

ARE ANY OTHER AGENCIES INVOLVED WITH THE FAMILY? _____ IF YES EXPLAIN: _____
_____

DEVELOPMENTAL AND MEDICAL HISTORY OF THE CHILD:

PLEASE CIRCLE: IS THIS YOUR: NATURAL CHILD? ADOPTED? FOSTER CHILD? STEPCHILD?

IF THE CHILD IS YOUR NATURAL CHILD, WHERE DOES HE / SHE FALL AMONG YOUR OTHER CHILDREN?

(1ST BORN, 2ND BORN, 3RD BORN, OR ONLY CHILD? Etc.): _____

IF OTHER THAN YOUR NATURAL CHILD, AT WHAT AGE DID HE / SHE COME INTO YOUR FAMILY? _____

DID MOTHER HAVE ANY ILLNESS OR COMPLICATIONS DURING PREGNANCY WITH THIS CHILD? _____IF YES, PLEASE EXPLAIN:
_____

DID MOTHER TAKE ANY DRUGS, MEDICATIONS, ALCOHOL, OR TABACCO DURING PREGNANCY? _____
IF YES,PLEASE EXPLAIN:
_____

PREGNANCY WAS PLANNED_____UNPLANNED_____ FULL TERM_____ PREMATURE _____
BIRTHWEIGHT _____

WAS THERE ANYTHING UNUSUAL ABOUT THE DELIVERY OF THIS CHILD? _____ IF YES EXPLAIN:
_____

IF YOUR CHILD HAS HAD ANY PROBLEMS IN ANY OF THE FOLLOWING AREAS OF DEVELOPMENT, PLEASE BRIEFLY DESCRIBE:

SMALL MUSCLE DEVELOPMENT (FINGER/HAND COORDINATION):_____

LARGE MUSCLE DEVELOPMENT (WALKING, RUNNING, JUMPING):_____

SPEECH AND LANGUAGE:_____

TOILET TRAINING: _____

THINKING AND PROBLEM SOLVING: _____

GETTING ALONG WITH OTHER CHILDREN, MAKING FRIENDS: _____

SELF-CARE (FEEDING, DRESSING, GROOMING):_____

OTHER: _____

MEDICAL INFORMATION:

WHEN DID A PHYSICIAN LAST EXAMINE THE CHILD? _____

NAME OF PRIMARY CARE PHYSICIAN: _____MAY WE CONTACT? _____

PHYSICIAN'S ADDRESS: _____ PHONE: _____

LIST ANY MAJOR HEALTH PROBLEMS FOR WHICH THE CHILD IS CURRENTLY RECEIVING: _____

_____

LIST ANY MEDICATIONS THE CHILD IS NOW TAKING: _____

_____

I give my consent for my treatment provider at Fountaingate to release my record to my primary physician so that they may discuss my treatment: Signed_____ Date:_____

I do not give my consent for my treatment provider at Fountaingate to release my record to my primary physician so that they may discuss my treatment: Signed_____ Date:_____

LIST ALL MEMBERS OF THIS CHILD'S FAMILY AND OTHERS LIVING IN THE HOME:

NAME	AGE / BIRTHDATE	RELATIONSHIP	GRADE / OCCUPATION

FAMILY HISTORY:

PLEASE CHECK ALL THAT APPLY IN THIS CHILD'S FAMILY, PAST OR PRESENT:

	MOTHER	MOTHER'S FAMILY	FATHER	FATHER'S FAMILY
BIRTH DEFECTS	_____	_____	_____	_____
MENTAL RETARDATION	_____	_____	_____	_____
SCHOOL PROBLEMS	_____	_____	_____	_____
LEARNING PROBLEMS	_____	_____	_____	_____
MENTAL PROBLEMS	_____	_____	_____	_____
EMOTIONAL PROBLEMS	_____	_____	_____	_____
ALLERGIES	_____	_____	_____	_____
EPILEPSY	_____	_____	_____	_____
VISION PROBLEMS	_____	_____	_____	_____
HEARING PROBLEMS	_____	_____	_____	_____
DIABETES	_____	_____	_____	_____
ASTHMA	_____	_____	_____	_____
ALCOHOL / DRUG ABUSE	_____	_____	_____	_____
MARITAL CONFLICTS	_____	_____	_____	_____

OTHER CONDITIONS OR PROBLEMS:

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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