Outdoor Achievement Group, L.L.C.

Individual, Family, & Group Psychotherapy

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Referral Information & Biopsychosocial

******* THIS FORM MUST BE SAVED TO YOUR COMPUTER BEFORE BEING COMPLETED AND RETURNED *******

Name of Referral: ____ ☐ Male ☐ Female

Marital Status: ___________________ Ethnicity: ____________________________________

Date of Birth: ____________________ School/Grade: ________________________________
(if applicable)

Allergies: ____
(include medication, food, seasonal, etc., or indicate "None" if there are no allergies)

Additional Referral: ____ ☐ Male ☐ Female
(sibling or spouse)

Marital Status: ___________________ Ethnicity: ____________________________________

Date of Birth: ____________________ School/Grade: ________________________________
(if applicable)

Allergies: ____
(include medication, food, seasonal, etc., or indicate "None" if there are no allergies)

Parent(s) or Legal Representative(s): ____
(if different than name of referral)

Street Address: ___________________________________ Zip: ________________________

City: ___________________________________ State: _______________________________

Telephone: _________________________ Email: ___________________________________

Emergency Contact: ______________________________ **Telephone**: ___________________
(person not living in the home)

* *Please provide a copy of divorce decree, court order, or guardianship paperwork. When a couple is married, either parent can consent to the treatment of their minor child. In situations when a couple has joint legal custody, and in the absence of final decision-making authority, both parents must consent to the treatment of their minor child. In situations when one parent enjoys sole legal custody or has final decision-making authority, only that parent can consent to the treatment of their minor child.*

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Insured's Information

Name: ____ Date of Birth: ________________

Street Address: ____________________________________ Zip: _________________________

City: ____________________________________ State: ________________________________

Relationship to Patient: _____________________________

Insurance Information

Insurance Plan Name: _____________________________________

Policy#: __________________________ Group#: __________________________

Secondary Insurance Plan Name: ____________________________

Policy#: __________________________ Group#: __________________________

Eligibility & Benefits Information *(for office use only)*

Effective Date of Coverage: _____________ ☐ HMO ☐ PPO ☐ POS Other: _____________
(plan type)

Individual Deductible: $ ________________ ☐ Yes ☐ No Met/Remaining: $ ___________
(deductible met?)

Family Deductible: $ ___________________ ☐ Yes ☐ No Met/Remaining: $ ___________
(deductible met?)

Out-of-Pocket Limit: $ __________________ *(individual)* Out-of-Pocket Limit: $ ______________________ *(family)*

Co-Insurance/Copay: $ _________________

Benefits Notes:

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General Intake Questions

Persons living in the home(s) where the patient resides:

Name	Date of Birth	Relationship to Patient

Briefly describe the purpose and goals for therapy:

____
____
____
____
____

Briefly describe the patient's strengths and struggles:

____
____
____
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____

Briefly describe the patient's social and recreational interests:

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Medical and Psychiatric History

Has the patient or anyone in the home received counseling or been hospitalized for a psychiatric problem in the past *(please include approximate dates or patient's age)*? ☐Yes ☐No

If yes, briefly describe:

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____
____
____
____

Is there a history of mental illness in the family *(e.g., attention-deficit/hyperactivity disorder, schizophrenia, depression, anxiety, etc.)*? ☐Yes ☐No

If yes, indicate which family member and briefly describe:

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____
____
____
____

Does the patient or anyone in the home have significant medical problems *(e.g., autoimmune disease, cancer, diabetes, heart disease, etc.)*? ☐Yes ☐No

If yes, indicate who and briefly describe:

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____
____
____

Is the patient currently taking any prescription or over-the-counter medications? ☐Yes ☐No

If yes, please list:

Medication	**Dose**	**Frequency**	**Start Date**

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Does the patient or any household member use alcohol, tobacco, cannabidiol (CBD), or tetrahydrocannabidiol (THC) products? ☐Yes ☐No

If yes, indicate who and briefly describe:

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____

Has the patient or any household member experienced problems with substance abuse, gambling, or other addictions *(e.g., pornography, video games, shopping, etc.)*? ☐Yes ☐No

If yes, indicate who and briefly describe:

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____

Has the patient experienced thoughts of harming self or others or engaged in self-injurious behaviors *(e.g., cutting, burning, hitting self, etc.)*? ☐Yes ☐No

If yes, briefly describe:

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Does the patient have sleep problems *(e.g., problems going to sleep, staying asleep, early waking, restless sleep, nightmares, night terrors, etc.)*? ☐Yes ☐No

If yes, briefly describe:

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Family, Social, Educational, and Occupational History

Has the family experienced any significant life stressors past or present *(death, chronic illness, financial, relocation, etc.)*? ☐Yes ☐No

If yes, briefly describe:

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Has the family experienced, or has the patient witnessed intense couple conflict, domestic violence, or sexual violence? ☐Yes ☐No

If yes, briefly describe:

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Has the patient experienced childhood abuse, neglect, traumas, serious injuries, or involvement with child welfare *(please include any serious injurie(s) requiring medical attention)*? ☐Yes ☐No

If yes, briefly describe:

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Has the family experienced divorce, remarriage, or blending *(please include approximate dates or patient's age for marriage, separation, and/or divorce)*? ☐Yes ☐No

If yes, briefly describe:

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Briefly describe the marriage or other close interpersonal relationships *(e.g., romantic, friendship, etc., parents please describe your own relationships)*:

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Please describe how the family gets along together *(e.g., parents, siblings, grandparents, in-laws, coparenting, etc.)*:

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Briefly describe educational and occupational history *(adults & parents only)*: ☐Not Applicable

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Intake Questions for the Parents of Children & Adolescents

Are the child or children's immunizations up to date? ☐Yes ☐No

Has the child or children had a recent vision and hearing screening? ☐Yes ☐No

Did the child or children's mother experience any prenatal, labor, delivery, or post-natal complications? ☐Yes ☐No

If yes, briefly describe:

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Has the child or children experienced any problems with physical or sexual development *(please include delays associated with speech or language development or problematic sexual behaviors)*? ☐Yes ☐No

If yes, briefly describe:

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Briefly describe the child or children's social development *(e.g., relationships with family, friends, teachers, etc.)*:

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Briefly describe the child or children's intellectual development and academic history *(e.g., academic performance, problems with specific subject area(s), and classroom behaviors)*:

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Does the child or children have any special modifications or accommodations in the classroom *(e.g., individualized education program (IEP) or 504 plan)*? ☐Yes ☐No

If yes, briefly describe:

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