Judith Moore, MFT
140 B St., Davis, CA 95616

Child Biographical Information and Symptom Description

Please fill this form out as completely as possible; it will help me in our work together. If you feel uncomfortable answering a question, that's ok. Just write, "Do not care to answer" in the space provided.

Child's Name: ______________________________ **Date:** ________________

Child's Date of Birth: ____________________ Age ______ Gender: ____________

Parent/Guardian Information: Please provide biographical information on each important parent/guardian in your child's life. Include biological, step, foster, and adoptive parents. (Can use back of paper too.)

Adult 1 Name: ________________________ Relationship: ________________
Phone Number: ____________________ Email: ___________________________
Is it ok to leave confidential/private messages at the phone number provided? Yes / No
Address: ____

Adult 2 Name: ________________________ Relationship: ________________
Phone Number: ____________________ Email: ___________________________
Is it ok to leave confidential/private messages at the phone number provided? Yes / No
Address: ____
Who referred you? ____

Emergency Contact other than primary parent/guardian(s):
Name: ___________________________________ Phone: ________________

Family Medical History
Please list any medical illnesses that run in the family.
____

____

Medical History of Child
Pediatrician: ______________________________ Phone number ____________
Other Medical doctors / specialists:
Name___________________________________ Phone number ____________
Date of last physical exam: ____
Please tell me about any major medical conditions, surgeries, accidents, or illnesses: __________
____

List all medications your child is currently taking. Include dosages and reason for taking _______
____
Please describe child's overall health today ______________________________

Is child experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. ____

____

Please indicate if your child has experienced any of the following Symptoms: Yes / No
If 'yes', at what age did they start?

__Severe headaches

__Fainting spells

__Hearing impairment

__Difficulty with speaking

__Difficulty with sleeping

__Asthma

__Frequent nausea/vomiting

__Soiling self

__Head injury

__Seizures or convulsions

__Vision problems

__Heart disease

__Abrupt weight gain/loss

__Frequent diarrhea/constipation

__Bedwetting

__Allergies (medication, food, pollen, etc)

Other ____

Current Symptoms/Concerns

Please place a check next to current concerns / symptoms.

___Headache

___Weight Change

__ Binge eating

___Anxiety/Worry

___Trauma

___ Refusal to share

___Panicky feelings

___Hyperactive

___ Risk taking

___Sexualized play

___Stomach aches

___ Bowel trouble

___ Muscle aches

___ Fears

___Low self-esteem

___Sleep problems

___Always tired

___School issues

___ Suicidal thoughts/actions

___Developmental delays

___Nightmares

___ Grief/Loss

___ Withdrawn

___ Sad / Hopeless

___ Foster/Adopted

___Frequent tantrums

___Aggression

___Disobedient

___ Self-harm

Please give explanation of social concerns such as Parental Divorce/Separation ____________________
____
Child's Performance at school ____
____
Denies affection from parents ____
____
Acts older/younger than age ____
Adjustment difficulty ____
____
Communication difficulty ____
Experienced trauma/Other Abuse ____
____
What are your Child's interests and hobbies? ___________________________________
____

Favorite stuffed animal, toy, book ____
____

What unique things would you like me to know about your child's personality? ____________________
____

Briefly describe your reason for seeking help at this time: ___________________________
____
____

What do you hope to accomplish in therapy?
____

Has child ever received psychiatric, psychological or counseling services of any kind before? Y/ N

If yes, please explain, when, with whom, and the outcome:
____

____

Please list the members of your family and all others who live in your home:

Name(s)	Age/Birthdate	Relationship	Occupation

Please add any additional information that you feel may be useful: ______________________________

____

Financial Information:
How do you intend to pay for treatment? (Venmo, check, Insurance)
____

Private pay clients are billed at $150 per session paid at the time of service.

f planning to use health insurance:
Name of Insurance Company ____
Name of Primary Insured (if a parent or other) _____________________________
Policy # ____
Tel. number on Ins. Card for Mental Health Services ___________________________

Telephone Number of Insured____
Address of Insured____
Primary Insured's Social Security Number______________________Insured's DOB ______________________
Is Authorization required? ______ If yes, Authorization # ______________________________
Number of sessions allowed per year or per Authorization ______________________________
Is there a deductible? __________ If yes, what is it per year ______________________________
Is there a co-pay per session for which you are responsible? _______ How much per session? _________________

Insurance Assignment, Information Release and Consent to Treatment:
I the undersigned, certify that **I have reviewed the attached treatment agreement and privacy policy**; give my consent to treatment and that I have insurance coverage with ______________________________ and **assign directly to Judith Moore, MFT** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges, whether or not paid by insurance.** I hereby authorize the release of all information necessary to secure the authorization of services, insurance case audit and the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ____ Date _________________

Responsible Party Signature ____ Date _________________

I understand that this is a contract for services rendered. If client does not give cancellation notice of 24 hours prior to appointment time, client is aware he/she/they will be responsible for payment of Judy Moore's full fee for service. By signing, you agree to pay $150 for any missed appointment unless Judy extends a courtesy fee of her contracted rate with your insurance company.

Responsible Party Signature ____ Date _______________

Responsible Party Signature ____ Date _______________

Please be advised that I do not write reports for Disability, Workman's Compensation, Divorce Cases or Child Custody Cases.

Due to Covid 19, all sessions are being conducted by Zoom, Face time or cell phone.

I understand that Judith Moore has a 24-hour cancellation policy and that if I do not cancel any appointment with her prior to that time, I will pay her professional fee of $150 per session.

Please be advised that I do not write reports for Disability, Workman's Compensation, Divorce Cases or Child Custody Cases.

Due to Covid 19, all sessions are being conducted on Zoom, Facetime or cell phone.

Completed by: ____ Date: __________________

I have been provided a statement of the HIPPA regulations regarding the Privacy Act and the legal communication of private medical records on Judith Moore's website: **judymooremft.com**

Name ____ Date ______________________

Name ____ Date ______________________

I have been provided a statement of Patient's Rights and Responsibilities on Judith Moore's website: **judymooremft.com**

Name ____ Date ______________________

Name ____ Date ______________________