Kim Loewen, Psy.D.

Clinical Psychologist PSY23978
3990 Old Town Ave, Ste A208 ~ San Diego, CA 92110
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NEW PATIENT INFORMATION (CHILD AGE 5-18)

Date_____
Patient Name_____ Sex _____ Age_____ DOB ___/___/___
Parent/Guardian Name (filling out paperwork)_____ DOB___/___/___
Address_____
City_____ State ____ Zip _____
Parent Phone #_____Email_____
Other Parent Name and Phone # (optional)_____
Child's Phone # (if ok to call him/her directly)_____

How did you hear about my practice? _____

RESPONSIBLE PARTY FOR BILL (if other than patient):
Name_____ Relationship to patient _____
Address_____
City _____ State_____ Zip_____
Home phone # _____ Work phone #_____

If using Insurance…

INSURANCE INFORMATION:
Company_____
Phone # _____
Name on insurance card _____
Social Security #: _____
Insured's Relationship to Patient: Self ( ) Spouse ( ) Child ( ) Other ( )
Insured ID# _____
Group or Plan # _____
Effective Date of Insurance _____
Authorization (for Medi-Cal)_____

If Not Using Insurance…

By signing below, I agree to pay a fee of $____ per hour to Kim Loewen, Psy.D. for services provided. I understand that this fee is subject to change, and that any change in fee will be as mutually agreed upon. I understand that my fee is subject to periodic review, particularly if my financial situation changes and I am paying a reduced fee. I agree to pay for services at the time they are provided, or as frequently as mutually agreed upon. If I am utilizing my health insurance to pay for these services, I hereby assign any payments from my health insurance provider to Kim Loewen, Psy.D., and I authorize release of information necessary to process a claim with my insurance company. I hereby accept responsibility for any charges not covered by my insurance, and for missed appointments or cancellations with less than 24 hour notice.

Signature _____ Date _____
(If a minor, parent or guardian must sign.)

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INTAKE QUESTIONAIRRE

SOCIOCULTURAL BACKGROUND:

Racial/Ethnic Background (i.e. Asian-American, Latino/a, White, etc)
Please specify how you identify yourself and your child:_____

How much does your family identify with your ethnic heritage?
Not at all A little Somewhat Moderately Strongly

Do you or your child identify yourselves in other ways that are meaningful to you (e.g., cultural background, sexual orientation, class status, physical ability)**? Please describe:**

_____

Religious preference: _____
Are you currently active in your religion? Yes Somewhat No
Is your child? Yes Somewhat No

FAMILY BACKGROUND:

Please list the members of your child's family, their sex, occupation, and age (e.g. Joseph, father, M, Lawyer, 52; Yolanda, sister, F, teacher 25):

Family Member Name Relationship Sex Occupation Age

_____
_____
_____
_____
_____
_____

Who currently lives with you and your child?_____

How much conflict do you currently experience within your family (circle one)?
Very little or none Some Moderate Strong Extreme

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PARENT/GUARDIAN:

Please fill out the following information with regard to your own history/background. If anything is confusing or you would prefer not to answer it, please leave it blank*

SUPPORT SYSTEM:

Please indicate your current relationship status (circle one):
Single In a Committed Relationship Living with Partner Married Separated Divorced Widowed
Other:_____

Besides family, who else do you count on for support? _____

ACADEMIC/ WORK BACKGROUND:

Place of employment: _____
Hours worked per week: _____ Years with employer: _____
Position: _____

PHYSICAL HEALTH:

How is your physical health at present (circle one)?
Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):
_____
_____
_____

Do you have a disability (circle one)? No Yes
If yes, please specify _____

MENTAL HEALTH HISTORY:

Have you received counseling for yourself? Yes No
If yes, where: _____ When: _____ Duration: _____
What was the focus of your treatment? _____

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ALCOHOL AND DRUG USE:

How often do you drink alcohol?
Daily 3+ times per week 1-2 times per week 1-2 times per month Less than once per month Never

How much do you drink? (i.e. # beers/wine/shots per day) _____

How often do you use other drugs (marijuana, cocaine, ecstasy, meth, oxycontin, etc)?
Daily 3+ times per week 1-2 times per week 1-2 times per month Less than once per month Never

What other drugs do you use? _____

Do you feel you need to cut down or stop using alcohol and/other drugs? Yes No Maybe
If so, please explain:_____

Has a friend or family member expressed concern about your alcohol or drug use? Yes No Maybe

CHILD:

Please fill out the following with regard to your child

What are you primary concerns about your child (what prompted you to bring your child in for treatment)?

_____
_____
_____
_____
_____

What grade is your child in?_____

Name of School/Teacher?_____

Describe your child's academic performance:

_____
_____
_____

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Has child's academic performance been consistent over the years? Or, has there been significant change in his/her performance recently?

_____
_____
_____

Does your child currently have an IEP, or has he or she had one in the past?

_____
_____

How does child spend most of his or her free time?

_____
_____
_____

Would you say your child has any trouble socially (Circle one)? Yes No

If so, please describe_____
_____

Have there been any life changing events in child's life that I should know about?

_____
_____
_____
_____

Please list any persistent physical symptoms or health concerns your child experiences (e.g. chronic pain, headaches, diabetes, etc.):

_____
_____
_____

Has child suffered any physical/verbal/emotional/sexual abuse to your knowledge (circle one)?

Yes No

If yes, has this been reported to CPS (circle one)? Yes No

If CPS has been involved…

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Name/Phone Number of Social Worker:_____

When was case opened?

_____

When was it closed? What were the findings?

_____

To your knowledge, has your child tried or does he or she regularly engage in the use of alcohol or recreational drugs (circle one)? Yes No

If yes, please describe:

_____

_____

Has your child ever expressed intention to hurt him or herself? If yes, has he or she ever attempted to hurt him or herself?

_____

_____

Has he or she ever threatened or attempted suicide? If yes, what happened?

_____

_____

Is your child currently on any psychiatric medication (circle one)? Yes No

If yes, which one(s)? _____
Name/Phone Number for Psychiatrist:_____

If no, are you interested in referrals for medication evaluation by a psychiatrist (circle one)?
Yes No

Has he or she taken medications in the past (circle one)? Yes No

Has your child ever received psychological services in the past (circle one)? Yes No

If yes, when/for how long?

_____

_____

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In what ways have you attempted to cope with child's current difficulties?

_____
_____
_____

How many counseling sessions do you anticipate needing/wanting?

1-6 7-12 12-20 20+

How motivated is child to work on current issues?

Not at all A little Somewhat Moderately Extremely

How hopeful are you that treatment will help your child?

Not at all A little Somewhat Moderately Extremely

List your strengths and qualities you admire about your child:

_____
_____
_____
_____

SIGNATURE:

I verify that the above information is accurate to the best of my knowledge.

_____ _____ _____

Printed Name (parent) Signature (parent) Date