LEGACY CENTER
19751 E. MAINSTREET SUITE 218 - PARKER CO 80138
PHONE: 303-841-4005 - FAX: 720-851-4890
INFO@LEGACYPARKER.COM - WWW.LEGACYPARKER.COM

Child's Demographic Information:

Last Name: _____ First Name: _____MI: _____ Birthdate: _____ Gender: _____

Nickname: _____ Ethnicity (Optional): _____

Address: _____ City:_____ Zip: _____

Home Phone: _____

Mother's Cell: _____ Father's Cell: _____ Child's Cell: _____

List all phone #'s you authorize Legacy to leave messages on: _____

Who should be contacted to schedule appointments? _____

I authorize Legacy to send Newsletters and/or program updates via e-mail and/or mail: ____ Yes ____ No

Parent/Guardian Information:

Mother's Name: _____ Mother's Address: _____

Mother's Email: _____ Mother's Employer: _____

Father's Name: _____ Father's Address: _____

Father's Email: _____ Father's Employer: _____

Who is financially responsible for this child? _____

Primary Insurance Information:

Who is responsible for payments made to Legacy (Parent Name)? _____

Insurance Company Name: _____ID #: _____ Group #_____

Policy Holder Name: _____Policy Holder DOB: _____

Form filled out by: _____ Signature: _____ Date:_____

Attended Intake Session: _____ Date Intake Completed: _____

Referral Information:

Who referred you to Legacy Center? _____

Referring Provider's Profession (**circle**): Physician/Pediatrician Teacher Counselor Other: _____

Reason for the Referral? _____

Current Concerns (Main reasons for coming to Legacy):	**LCCC Office Use Only**
Current Concern #1: When did the problem begin: What have you tried that has worked: What have you tried that has **not** worked:	
Current Concern #2: When did the problem begin: What have you tried that has worked: What have you tried that has **not** worked:	
Current Concern #3: When did the problem begin: What have you tried that has worked: What have you tried that has **not** worked:	
What are your primary goals for seeking treatment for your child? 1. 2. 3.	
What is your child's understanding of why he/she is coming to Legacy?	

Current Concerns (Main reasons for coming to Legacy) (continued):	**LCCC Office Use Only**
Is your child experiencing any of the following? ___ Sad or depressed ___ Loss of interest ___ Energy loss ___ Withdrawal ___ Weight change ___ Change in eating habits or appetite ___ Too little sleep ___ Too much sleep ___ Worthlessness/Guilt ___ Suicidal plans ___ Suicidal thoughts ___ Verbal Aggression ___ Physical Aggression ___ Anxiety ___ Meltdowns/Tantrums ___ Disorganization ___ Forgetfulness ___ Concentration Difficulties ___ Constant Motion ___ Impulsivity ___ Hyperactivity ___ Irritability ___ Angry or mad ___ Restlessness ___ Behavior problems ___ Nightmares ___ Harm towards self ___ Defiance ___ Fearfulness ___ Difficulty with changes in routine Anything else:	

List all family members living in your child's home:				**LCCC Office Use Only**
Name:	Gender:	Age:	Relationship to **CLIENT**:	

Family Information:	**LCCC Office Use Only**
Maternal Education:	
Paternal Education:	
Primary language spoken in the home:	
Secondary language spoken in the home:	

Family Information (continued):	**LCCC Office Use Only**
Are the biological parents of the client married? ____ Yes _____ No **If NO, please provide co-parent consent form signed by both parents.** What are the Legal Custody arrangements for your child? Who has medical care decision making for your child? Who has mental health care decision making for your child?	
Describe any current or previous family Child Protective Services involvement:	
Does your family currently have a caseworker? _____Yes _____No If yes, who? _____	

Developmental History:	**LCCC Office Use Only**
Did the biological mother receive prenatal care during the (check the box that applies): First Trimester: □ Yes □ No Second Trimester: □ Yes □ No Third Trimester: □ Yes □ No	
Prescription Medications/ Over the counter drugs used by mom during pregnancy (specify trimester):	
Illicit drugs, marijuana, alcohol, and/or cigarette use during pregnancy (specify trimester, frequency, and amount):	
Medical Interventions during pregnancy:	

Birth History:	**LCCC Office Use Only**
Child's gestation: _____ Weeks	
Weight: _____lbs. _____oz.	
Medications used during child's labor/delivery: _____Yes _____No	
Type of delivery:	
Complications: _____Yes _____No If yes, please describe:	
Child's physical condition at birth:	

Birth History (continued):	**LCCC Office Use Only**
Was the child admitted to the NICU? _____Yes _____No If yes, please describe interventions: If yes, how long was your child in the NICU?	

Developmental Skill:	**Age Acquired**	**Concerns**	**LCCC Office Use Only**
Sat alone			
Crawled			
Stood alone			
Walked alone			
Does your child ever walk on his/her toes? Yes ____ No_____			
Said single word What was 1st word?			
Said 2-3 word sentences			
Toilet training	Day: Night:		
Fine Motor Skills (Pincer grasp, pencil grasp, etc.)			
Eye contact			
Responded to smile			
Parallel play (Played same activity side by side)			
Interactive play (Play that involves sharing and turn taking)			
Identified a best friend			

Medical History:	**LCCC Office Use Only**
Describe any significant past/current illnesses:	
Describe any significant past/current surgeries:	
Describe any significant past/current allergies:	
Does your child have an autoimmune deficiency? If so, please describe:	
Describe any past hospitalizations:	
Describe any past psychiatric hospitalizations:	
Describe any significant past/current head injuries/concussions: Did your child lose consciousness? _____Yes _____No If yes, for how long? _____ Did you seek medical attention for your child? _____Yes _____No What other symptoms did your child experience?	
Describe any accidents/trauma:	
Describe any environmental trauma your child may have experienced (e.g., tornados, floods, hurricanes, etc.):	
Describe any sexual/physical/mental abuse:	
Describe any concerns regarding your child's vision: Date of most recent vision exam: _____	
Is your child color blind? If yes, please explain:	
Describe any concerns regarding your child's hearing: Date of most recent hearing exam: _____	

Medical History (continued):	**LCCC Office Use Only**
Describe your child's sleep patterns? Where does your child sleep? _____ Does your child have difficulty falling asleep? _____Yes _____No If yes, please describe: Does your child have difficulty staying asleep? _____Yes _____No If yes, please describe: Does your child snore? _____Yes _____No If yes, please describe:	
Describe your child's appetite?	

Child's Prescribing Physician:	**LCCC Office Use Only**
Physician's Name: _____ Physician's Phone: _____ Physician's Address:	

Medication History:						**LCCC Office Use Only**
Prescribed Medication	Purpose of Medication	Dose	Date Began	Date Ended	Response to the medication and why it ended?	

Medication History (continued):						
Holistic or Homeopathic Medications	Purpose of Medication	Dose	Date Began	Date Ended	Response and why it ended?	

Family Medical History:	**LCCC Office Use Only**
List any learning/educational problems in your child's family history: _____Immediate/Extended _____Immediate/Extended _____Immediate/Extended	
List any mental health problems in your child's family history: _____Immediate/Extended _____Immediate/Extended _____Immediate/Extended	
List any drug or alcohol problems in your child's family history: _____Immediate/Extended _____Immediate/Extended _____Immediate/Extended	

Therapy / Treatment History:			**LCCC Office Use Only**
Treatment Provider	Type of Service (Speech therapy, occupational therapy, physical therapy, vision therapy, etc.)	Approximate Dates of Services	
Has your child been diagnosed with a mental health diagnosis? _____Yes _____No If yes, what diagnosis was given? What provider gave the diagnosis?			
Has anyone (besides the current referring provider) ever recommended that your child receive an evaluation or assessment? _____Yes _____No If yes, who? Why was a recommendation made for an evaluation?			

Therapy / Treatment History (continued):	
Has your child ever received counseling in the past? _____Yes _____No If yes, who was the treating provider? What diagnosis was your child being treated for? What were the goals in treatment? How do you feel your child responded to the counseling services provided? Were any further recommendations made by the treating provider? If yes, what were they?	
Has your child had previous testing? (Tutoring center, school, child find or early intervention)? _____Yes _____No _____ Date of Evaluation **If yes, please provide Legacy Center with copies of previous evaluations.** If yes, please described the type of testing your child received: Did your child receive a diagnosis? _____Yes _____No If yes, what diagnosis was given: What recommendations were made as a result of the evaluation?	
Is your child currently receiving any alternative therapies? (Acupuncture, homeopathic, herbal, biofeedback, etc.)? _____Yes _____No If yes, please explain:	
Has your child received genetic testing to assess for chromosomal abnormalities? _____Yes _____No If yes, what were the results? If no, has genetic testing ever been recommended? If yes, why?	

Sensory History:	**LCCC Office Use Only**
Is your child sensitive to sights, sounds, textures, flavors, smells, or other sensory input? _____Yes _____No If yes, please describe:	
Does your child appear highly interested in sights, sounds, textures, flavors, smells, or other sensory input? _____Yes _____No If yes, please describe:	
Does your child appear clumsy or uncoordinated? _____Yes _____No	
Would you describe your child as a picky eater? _____Yes _____No	
Please list any other sensory concerns:	

Behavior History:				**LCCC Office Use Only**
Concerning Behavior	Age Began-Age Ended	Severity on a scale of 1-10 (10 being worst)	If known, triggers of behavior problem (people, events, etc)	

Behavior History (continued):	**LCCC Office Use Only**
Please describe your child's typical mood:	
Please describe your child's personal strengths:	
Please list any of your child's extracurricular activities:	
Does your child repeatedly say any words over and over? _____Yes _____No	
Does your child display any repetitive behaviors? _____Yes _____No (e.g., spinning, turning off and on lights, lining up toys, stacking objects, etc.) If yes, describe:	
Has your child ever had an ability or skill and then lost it? _____Yes _____No If yes, please indicate what skill(s) your child lost and for how long:	
Does your child have any restricted interests (an interest that is all encompassing or unusual in its intensity)? _____Yes _____No If yes, please describe:	
Do you have concerns about your child's coping skills? If yes, please describe: What coping skills does your child use when upset?	
Does your child use any alcohol and/or illicit drugs? _____Yes _____No If yes, please describe:	
Has your child had any legal or criminal issues or involvement with law enforcement authorities? _____ Yes _____ No If yes, please describe issues and date(s) of involvement:	

Discipline History:				**LCCC Office Use Only**
Method:	Frequency:	Consistency among caregivers?	Effectiveness	

Social History:	**LCCC Office Use Only**
Are there any concerns about your child's ability to form/maintain friendships? _____Yes _____No If yes, describe:	
Are there any concerns about your child's social skills? _____Yes _____No If yes, describe:	
Who does your child prefer to spend time with?	

School History:				**LCCC Office Use Only**
Name of School	Grades Attended (in years)	Child's Behavior	Academic of Special Services Received	
Current School:	Current Grade:			

Does your child like school? _____Yes _____No If no, please describe:	
Has your child ever repeated or skipped a grade? _____Yes _____No If so, which grade?	

School History (continued):	
How does your child respond to redirection for behavior at school?	
Has your child had any suspensions or detentions? _____Yes _____No If yes, please describe:	
Does your child have a current or past: IEP (Individualized Education Program)? ____Yes ____No Date of most recent plan: _____ ILP (Individualized Learning Program)? ____Yes ____No Date of most recent plan: _____ RTI (Response to Intervention)? ____Yes ____No Date of most recent plan: _____ 504? ____Yes ____No Date of most recent plan: _____	
If you answered YES to any of the questions above, please describe the type(s) of services your child receives:	

Please indicate any other concerns you may have about your child that you feel would important for your provider to know:

_____

_____

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_____

Legacy Center Credit Card on File

Date: _____

Client's Name: _____

Client's DOB: _____

As a courtesy Legacy Comprehensive Counseling & Consulting will bill your insurance company for their portion of the fee if the therapist you are seeing is in your insurance company's network. Payment of your deductible, co-pay and/or co-insurance is your responsibility and may be collected from you at the time the service is rendered. Some services (including some psychological testing services) may be processed through your insurance company before you are charged for your portion. In these situations, your credit card on file will be charged for your portion (copays, deductible, co-insurance) immediately after Legacy Center receives notice of your amount due from your insurance company. Legacy Center is unable to give an estimation of when your credit card on file will be charged due to the unknown length of time that your insurance company will take to process your claim. If your insurance company denies payment for any reason, the entire fee is your responsibility and will be charged to your credit card on file upon notice of denial from your insurance company. ***WE ACCEPT ALL CARDS EXCEPT AMERICAN EXPRESS***

I, _____, authorize the use of my credit card for the following charges: Appointment fees including, but not limited to, co-pays, co-insurances, deductibles, private pay fees, and charges denied by your insurance company, as well as charges related to No-Shows, Late Cancels and Late Fees.

Signature: _____ Date: _____

Authorized Credit Card Information **(Please note that a credit card is required)**

Card Number : _____ - _____- _____ - _____

Expiration Date : _____ / _____

Billing Zip Code: _____

Card Holders Name: _____

Card Holders Signature: _____ Date: _____

If you would like us to first try to run appointment fees through your HSA or FSA card prior to charging the remaining balance left over to your credit card, please fill out your HSA/FSA card information below (Please note: We will not bill charges related to no-shows, late-cancels or late fees to your HSA/FSA card; these charges will go directly to your credit card on file.)

Authorized HSA/FSA Card Information

Card Number : _____ - _____- _____ - _____

Expiration Date : _____ / _____

Billing Zip Code: _____

Card Holders Name: _____

Card Holders Signature: _____ Date: _____