

Stress and Anxiety Services of New Jersey, LLC

A-2 Brier Hill Court
East Brunswick, NJ 08816
www.StressAndAnxiety.com

Phone: (732) 390-6694
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Hello, and welcome to our link for New Client Forms for Minors!

If you have already contacted our office and scheduled an appointment, this link is designed to save you time during our initial interview.

On the following pages are two forms; one-page Insurance Information Form, and a three-page Pre-Intake Form. These forms are NOT set up to be filled out online and electronically submitted. Instead, print out this form (you can tell your printer to print out pages 2-5, so that you only get the form itself- also, please remember to set your printer up so that it prints in portrait, NOT in landscape). Then fill out this form before you come in for your first session and bring it in with you when you come in for your appointment.

This will allow for the best use of our time during the initial session, as there are many other questions that we will review during our initial meeting. If you are not sure how to answer something, just leave it blank. We will review all the information you have provided in these forms, so that if you need to clarify anything, you can do so at that time.

Although we do not take insurance at this time, please note that we still request that you fill out the insurance form for our records. Thank you in advance.
Looking forward to working with you.

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INSURANCE INFORMATION FORM-Please print clearly

Name of child/adolescent _____ Birth date _____

Name of parent or guardian _____

Home phone (_____) _____ Business phone (_____) _____

Cell phone of parent(_____) _____ Email of
parent _____

Address _____

Whom may we thank for referring you? (name) _____

(address) _____ (tel) _____

Marital status of parent: Single ____ Married ____ Divorced ____ Widowed ____

Social Security number of insured _____ - _____ - _____

Person financially responsible for this account _____

Relationship to client _____ Address (if different from client's)

Insurance company name & address _____

_____ Insurance ID # _____

Subscriber's name (if different from client's) _____

Subscriber's birth date (if different from client's) _____

I authorize this office to release any information necessary to expedite insurance claims.
I understand that I am responsible for all for all charges, regardless of insurance coverage.

Parent or Guardian signature _____ Date _____

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PRE- INTAKE FORM FOR MINORS- **please print clearly**

Name of minor _____ DOB _____ Age _____

Parent(s) (first name/age) _____

Siblings (first names/ages) _____

Who is living in your present home with client?

Grade level _____

Name of School _____

Address of school (NO CONTACT will be made without written permission from parent/guardian)

Telephone number of school _____ School contact _____

Has client been classified? yes no (if yes, please try to bring any testing results)

If yes, has there been an IEP (504 plan) developed? yes no (if yes, please try to provide a copy)

How does client perform academically? Below Average Average Above Average

Particular problems academically/socially in school?

Parent Employed? No Part Time Full Time

(if no, skip to Present medical conditions)

Where employed? _____

Present employment position _____

Present medical conditions of client (high blood pressure, diabetes, allergies, etc.)

History of medical (non-psychiatric) hospitalization? Yes No

If yes, please indicate year and reason

Is client taking any prescription medication now (psychiatric or otherwise)? Yes No

If yes, indicate Name of Medication, Dosage, Since When Taken, and any Present Side Effects:

Please provide the name, address and phone number of any physician currently prescribing psychiatric medication for your child. If you need more room, please write on separate 8"x 11" paper.

Please list any additional psychiatric medications that your child has previously been on:

Has your child had any psychiatric hospitalizations? Yes No

If yes, please indicate where and approximate dates:

Has your child been in therapy before? Yes No

If yes, please indicate the name of the therapist, address and telephone number, and the approximate beginning and end dates of treatment. If multiple therapists, it is not necessary to provide names of people you have seen for only a very short time. If you need more room, please write on separate 8" x 11" paper.

Thank you for your information.