CLIENT INFORMATION FORM FOR FAMILIES WITH CHILDREN

General Information: Today's Date: ___/___/___ Social Security # _____
Required for insurance reimbursement - otherwise never disclosed w/o consent

Birthdate: ___/___/___ Age _____ Male ☐ Female ☐

Child's Name: _____ *Goes by* (_____)

Address: _____ City, state, zip code: _____

Who referred you to us? _____ May we let them know you came? Yes ☐ No ☐

Parent/Guardian Information: Child Lives With: _____

Child's Legal Guardian(s): _____

Mother's/Guardian's Name: _____ Social Security # _____
Required for insurance reimbursement - otherwise never disclosed w/o consent

Address: _____ City, state, zip code: _____

Home Phone: _____ e-mail: _____

Work Phone: _____ Cell Phone: _____

Employer/Occupation: _____ Where may we contact you? Home ☐ Work ☐ Cell ☐ Email ☐

Father's/Guardian's Name: _____ Social Security # _____
Required for insurance reimbursement - otherwise never disclosed w/o consent

Address: _____ City, state, zip code: _____

Home Phone: _____ e-mail: _____

Work Phone: _____ Cell Phone: _____

Employer/Occupation: _____ Where may we contact you? Home ☐ Work ☐ Cell ☐ Email ☐

NAME(S) OF ALL THOSE LIVING IN HOUSEHOLD	AGE	SEX	RELATIONSHIP TO CLIENT
NAME(S) OF FAMILY **NOT** LIVING IN HOUSEHOLD	AGE	SEX	RELATIONSHIP TO CLIENT

Billing Information (for self-pay/out-of-network purposes only)**:**

BILLABLE PARTY:	RELATIONSHIP TO CLIENT:	PHONE NUMBER:
INSURANCE COMPANY:	GROUP POLICY #:	POLICY HOLDER ID:
ADDRESS:	CITY, STATE, ZIP CODE:	
POLICY HOLDER DATE OF BIRTH:	POLICY HOLDER SSN:	

Emergency Information:

Emergency Contact (not parent(s)/guardian(s)): _____ Relationship to Client: _____

Home Phone: _____ Other Phone: _____

MEDICAL HISTORY

Primary Care Physician: _____ Phone Number: _____

Address: _____ City, state, zip code: _____

Last Visit: _____ Why? _____

Is your child being treated for any medical condition(s)? Yes ☐ No ☐ Explain: _____

_____

Is your child allergic to any medication or food? Yes ☐ No ☐ Explain: _____

Is your child currently seeing a psychiatrist? Yes ☐ No ☐ If yes, please provide the following information:

Psychiatrist's Name: _____ Phone Number: _____

Address: _____ City, state, zip code: _____

Last Visit: _____ Main focus? _____

Please list any medications and dosage your child is taking or have taken within the last 6 months:

PRESCRIBED BY	PRESCRIBED FOR	NAME OF MEDICATION	DOSAGE (amount and frequency, *ex. 25mg once a day*)

Does your child have a previous/current therapist? Yes ☐ No ☐ If yes, please provide the following information:

Name of Provider _____ Main focus? _____ Date(s) of Service _____

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Check the following that apply to your child:

	Present	Past		Present	Past
Stomach trouble	☐	☐	Difficulty Separating	☐	☐
Change in appetite	☐	☐	Nervousness/Anxiety	☐	☐
Tired/Fatigued	☐	☐	Waking up at night/Nightmares	☐	☐
Isolation from others	☐	☐	Fears/Phobias	☐	☐
Headaches	☐	☐	Attention-Seeking Behaviors	☐	☐
Distractibility	☐	☐	Anger/Irritability	☐	☐
Hyperactivity	☐	☐	Academic Problems	☐	☐
Tearfulness	☐	☐	Substance Use/Abuse	☐	☐
Unexplained moods	☐	☐	Trauma/Abuse	☐	☐

Please explain and comment on any of these or other symptoms/problems that may be relevant to counseling: _____

_____

_____