

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	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Separating	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Tired/Fatigued	<input type="checkbox"/>	<input type="checkbox"/>	Waking up at night/Nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Isolation from others	<input type="checkbox"/>	<input type="checkbox"/>	Fears/Phobias	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Attention-Seeking Behaviors	<input type="checkbox"/>	<input type="checkbox"/>
Distractibility	<input type="checkbox"/>	<input type="checkbox"/>	Anger/Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Academic Problems	<input type="checkbox"/>	<input type="checkbox"/>
Tearfulness	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use/Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained moods	<input type="checkbox"/>	<input type="checkbox"/>	Trauma/Abuse	<input type="checkbox"/>	<input type="checkbox"/>

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