CLIENT INFORMATION

(for Minors)

Today's date_____

Client Name_____

Date of Birth_____ Age_____SS#_____

Address_____

Street (Apt. #) City State Zip code

Phone numbers: Home ( )_____ Work ( )_____

May we call you …at home? Y N …at work? Y N

Cell ( )_____ **Please circle primary number**

School_____ Grade_____

Family members (please give name and ages of immediate family members)_____

_____

_____

_____

INSURANCE INFORMATION (Please provide your insurance card for photocopying)

Insurance Carrier_____ Policy #_____

Subscriber Information: Name_____ DOB_____

Address_____ Subscriber SS#_____

Employer_____Client's relationship to subscriber_____

Insurance Company phone number_____

Assignment of Benefits & Release of Information

I hereby assign, transfer and set over to Provider, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until I provide written notice revoking said authorization. I understand that this does not relieve me of my obligation to pay any and all bills if not paid by my insurance company, or of any balance due after payments by my insurance company.

_____ _____

Patient/Guardian Signature and date Witness signature and date

Person to be contacted in case of an emergency

Name_____ Home phone number_____

Relationship_____ Work phone number_____

Medical History

Were there any complications during pregnancy with this child?_____

During pregnancy did Mother smoke? Y N

… take medications? Y N if yes, what_____

… drink alcohol? Y N if yes, please describe____ _____

Any complications during/after delivery? Y N if yes, please describe_____

Were there any feeding problems during infancy? Y N_____

Was your child colicky? Y N Were there any health problems during infancy? Y N if yes, please describe_____

Were developmental milestones within normal limits? Y N if no, please describe_____

_____

How is your child's overall health?_____

Are your child's immunizations up to date? Y N

Are there any sensory problems? Y N

Are there any fine or gross motor difficulties? Y N

Does your child have any chronic health problems? Y N

Is there any history of (circle if yes) broken bones, severe lacerations, head injury, pumped stomach, eye injury, teeth knocked out, stitches

Has your child had any surgeries or hospitalizations? if so,when_____

Is there any history or suspicion of physical or sexual abuse? Y N

Is there any history or suspicion of alcohol or drug use/abuse? Y N

Does your child use tobacco? Y N

Does your child have any problems sleeping (falling asleep, staying asleep through the night)? Y N

Does your child sleep alone? Y N

Does your child have any bladder or bowel control problems? Y N

Does your child have any appetite control problems? Y N

Is your child on any medications? if so, what_____

When was your child's last doctor's appointment?_____ What was it for?_____

Does your child have any known allergies?_____

Please use this space to further explain any of the above _____

_____

_____

_____

_____

_____

Educational History

Has your child had any problems academically?

Are any special classess or tutoring required?

Has your child ever been suspended or expelled from school?

How does your child get along with siblings?

How easily does your child make friends?

On average how long do friendships last? < 6 mos, 6 mos – 1 yr, 1 yr +, don't know

Please describe your reasons for seeking counseling now _____

_____

_____

_____

Psychiatric History

Has your child ever received psychiatric or psychological or substance abuse treatment of any kind before? __Y __N

If you checked Yes to the above question, please answer the following:

What type of care did you receive? __inpatient (hospital) __outpatient __both
When were you in treatment? _____
Where were you in treatment? _____
How long were you in treatment? _____
Who was your therapist or doctor? _____
Did your doctor prescribe medicine at that time? __Y __ N __Not applicable
If yes, what was prescribed (include dosage if known)? _____

Have any family members received psychological or psychiatric or substance abuse treatment? If so, please describe_____

_____

_____

_____

_____