CHILD/ADOLESCENT CLIENT INTAKE INFORMATION FORM

Counselor's Name:______________________________ Date:___________________

The information requested on this form will be kept confidential and will help your counselor assist you.

GENERAL INFORMATION (please print)

Last Name: _________________________ First Name: ____________________ MI: _____________

Mailing Address:________________________ City: ______________________ST:_____ZIP:________

Cell Phone: _______________________ Preferred? ____ Leave Message ____ Yes ____ No

Home Phone: _____________________ Preferred? ____ Leave Message ____ Yes ____ No

Work Phone: _____________________ Preferred? ____ Leave Message ____ Yes ____ No

Email: __________________________ ____ ____

DOB: ____________ Age: _____ Gender: ____ M ____ F SSN: __________________________

School attending: ____ Grade: ____________

Employment: (if applicable)

____

Reason you are coming for counseling:

____

Child's racial/ethnic identity: ___ African-American ___ Asian-American ___White/Caucasian ___ Hispanic
___ Other _______________________

Child's Religious/Denominational preference ______________________________________

How did you hear about our counseling center? __ Clergy ___ MD ___ Brochure ___ Family/Friend
__ Internet ___ Insurance ___ Therapist ___ Our Client

Referred by: ___________________________

FAMILY INFORMATION

Child's Parents are: ____Single ____Married/Partnered ____Divorced ____Widowed

Mother's Name: ____ DOB:_____________ Age: ___________

Home Phone: ________________ Cell Phone: __________________ SS#:____________________

Employer: ____ Work Phone:___________________

Father's Name: ____ DOB:_____________ Age: ___________

Home Phone: _________________ Cell Phone: __________________ SS#:___________________

Employer: ____ Work Phone:____________________

Other's living in child's home (names & relationship to child/age): ___________________________________

____

____

Legal Custodian (if applicable)

____

In case of emergency, contact:

____

Relationship: ___________________________________Emergency Phone: ___________________________

PAYMENT METHOD (Complete only if using insurance benefits)

Responsible party & address:______________________________

Primary Insurance Carrier: ______________________________

Street Address: ______________________________

City: ______________ State__________ Zip ____________ Phone:______________

Policy #: ______________Group#: ______________Preauthorization request? ___Yes ___No

Insured's Name: ______________________ DOB:__________ Relationship: ____________

Secondary Insurance Carrier: ______________________________

Street Address: ______________________________

City: ______________ State__________ Zip ____________ Phone:______________

Policy #:______________ Group#: ______________Preauthorization request? ___Yes ___No

Insured's Name: ______________________DOB:__________ Relationship:____________

Parent's Authorization:

I authorize the release of health care information necessary to process any claims generated by Canterbury Counseling Center.

____

Signature Date

I hereby authorize payment directly to Canterbury Counseling Center of any benefits due for counseling/ psychotherapy. I understand that I am responsible for any amount not covered by insurance.

____

Signature Date

COUNSELING CONCERNS

Why are you seeking help for your child now?______________________________

____

What would you like to see happen as a result of counseling or psychotherapy? ______________

____

MEDICAL & PSYCHOLOGICAL HISTORY

Physician's Name & Phone Number: ______________________Date of last physical: ________

List physical illnesses or symptoms: ______________________________

List current medications & dosages: ______________________________

____

Child's psychiatrist's name & phone number:______________________________

Has your child received counseling or psychotherapy in the past? ___Yes ___No

When?______________ Where?______________________________

Have you or any other family member received help for drug or alcohol dependency? ___Yes ___ No

When? ______________Where? ______________________________

TREATMENT PLAN

(To be completed in session with your therapist)

Type of Counseling: Individual Couple Family Group

Frequency of therapy ______________Treatment Goals: ______________

____

Referrals (specify): ______________________________

Client's Signature: ______________________Date: __________

Parent/Guardian Signature: ______________________Date: __________

Therapist's Signature: ______________________ Date: __________