

# 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.

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 \_\_\_\_\_

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: \_\_\_\_\_