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CHILD Client Information

PLEASE COMPLETE ALL FOUR PAGES

CLIENT NAME: ____Date:________________

Birthdate:______________________________Age:___________SS#:____________________________

Address/City/State/Zip:____Cell Phone:______________

PARENT/GUARDIAN #1:

NAME:_________________________________ Relationship to Client __________________________

Birthdate:______________________________Age:___________SS#:____________________________

Address/City/State/Zip:____

Home Phone:________________ | Work Phone:_________________ |Cell Phone:____________________
May we call you at home? yes no | May we call you at work? yes no | May we call your cell? yes no
May we leave a message? yes no | May we leave a message? yes no | May we leave a message? yes no

May we communicate with you by email if necessary? If so, give address:____________________________

Employer and Position:____ How long?_____________

Education level: ___Elementary ___High School ___Some College ___College Degree ___Grad Study

Marital Status: ___Single ___Married ___Live together ___Separated ___Divorced ___Widowed

Previous marriage(s)?:____

Religious/Church affiliation:____ ___Active ___Inactive

PARENT/GUARDIAN #2:

NAME:_________________________________ Relationship to Client__________________________

Birthdate:______________________________Age:___________SS#:____________________________

Address/City/State/Zip:____

Home Phone:________________ | Work Phone:_________________ |Cell Phone:____________________
May we call you at home? yes no | May we call you at work? yes no | May we call your cell? yes no
May we leave a message? yes no | May we leave a message? yes no | May we leave a message? yes no

May we communicate with you by email if necessary? If so, give address:____________________________

Employer and Position:____ How long?_____________

Education level: ___Elementary ___High School ___Some College ___College Degree ___Grad Study

Marital Status: ___Single ___Married ___Live together ___Separated ___Divorced ___Widowed

Previous marriage(s)?: ____

Religious/Church affiliation:____ ___Active ___Inactive

If parents are not married, who is the court-designated managing conservator?_______________________
We will need copy of court document designating conservatorship.

Name of stepfather:_________________________________ How long married to mother? ____________

Name of stepmother:________________________________ How long married to father? _____________

PERSONAL / FAMILY HISTORY: ***IF AN ISSUE DOES NOT APPLY, PLEASE MARK "N/A"***

SIGNIFICANT MEDICAL ISSUES OF CLIENT AND FAMILY MEMBERS:

Who	*Condition*	*Dates*	*Physician / Location*

PREVIOUS COUNSELING / THERAPY OF CLIENT AND FAMILY MEMBERS:

Who	*Reason*	*Dates*	*Counselor / Location*

PREVIOUS PSYCHIATRIC DIAGNOSES GIVEN OF CLIENT AND FAMILY MEMBERS:

Who	*Diagnoses*	*Dates*	*Physician / Location*

HOSPITALIZATION FOR PSYCHIATRIC CONDITIONS OF CLIENT AND FAMILY MEMBERS:

Who	*Reason*	*Dates*	*Physician / Hospital*

MEDICATIONS PRESCRIBED FOR PSYCHIATRIC CONDITIONS OF CLIENT AND FAMILY MEMBERS:

Who	*Medication/Dosage/Frequency*	*Date*	*Reason*	*Has it helped?*	*Physician*

HISTORY OF SUBSTANCE ABUSE FOR CLIENT & FAMILY MEMBERS: *(alcohol, illicit drugs, prescription drugs)*

Who	*Substance*	*Age/date started?*	*Age/date last time used?*	*Treatment?*

HISTORY OF ABUSE OF CLIENT: *(physical, mental/emotional, sexual)*

Type of abuse	*Dates / age*	*Perpetrator*	*Outcome*

HISTORY OF LEGAL PROBLEMS *(do not list traffic citations)***:**

Who	*Charge*	*Date*	*Arrested?*	*Conviction?*	*Outcome*

PRIMARY PHYSICIAN OF CLIENT: ____

When last seen____________________________ Reason ______________________________________

PERSONAL CONCERNS: *Please place a check mark next to the client's concerns.*

Depression	Anger	Alcohol/drug use	Sleep problems	Physical abuse	School performance
Anxiety/Worries/ Fears	Temper tantrums	Sexual activity	Bad dreams	Sexual abuse	Poor attention
Moodiness/ Unhappiness	Fighting	Lying	Bedwetting	Verbal/Emotional abuse	Hyperactivity
Complaining	Arguing	Stealing	Eating disorder	Relationship with parent	Immaturity
Shyness / Self-esteem	Manipulative behavior	Running away	Health problems / allergies	Relationship with stepparent	Other ______________
Jealousy	Disobedience	Impulsivity	Sexual concerns	Visitation arrangement	Other ______________

Why are you seeking help at this time?____

____

____

What do you wish to accomplish through counseling? ______________________________________

____

____

____

____

____

____

FAMILY MEMBERS: *please list all members of your household* (If more space is needed use bottom of page 4)

Name ***Relationship*** ***Age*** ***Birthdate*** ***School*** ***Grade***

1.____

2.____

3.____

4.____

5.____

Please list other siblings who are living outside of your home:

Name ***Relationship*** ***Age*** ***Birthdate*** ***School*** ***Grade***

1.____

2.____

Name of nearest relative **not** living with you:_______________________________ May we contact? yes no

Address;______________________________________Phone:_________________Relationship:_________

Who to contact in case of emergency:_____________________________________ Relationship:________

Address:__________________________________ Home Phone:____________ Work phone:___________

Were you referred here by anyone? YES NO If so, who?_______________

Please indicate any individual(s) you may want us to confer with during the course of your therapy, (i.e. physician, spouse, parent, child(ren), etc. If you are taking medication, it is often helpful to consult with the physician who prescribed your medicine. Your signature authorizes two-way consultation with the persons listed and releases your therapist and Paris Counseling Center, P.A. from liability resulting in the release/obtaining of information.

Name(s):_______________Relationship:_______________

Name(s):_______________Relationship:_______________

▶ Signature:_______________

CLIENT INSURANCE INFORMATION (MUST BE COMPLETED)

EMPLOYEE ASSISTANCE PROGRAM: *(If you will be using the benefits of an employee assistance program, please complete this information. If not, please skip to Primary Insurance Plan.)*

EAP COMPANY:_______________PHONE #:_______________

EMPLOYER:_______________

EMPLOYEE NAME:_______________DATE OF BIRTH:_______________

Have you spoken with the EAP company? ___yes ___no *(EAPs generally require the client to call and authorize.)*

Did they authorize sessions? ___yes ___no How many?_______ Authorization #:_______________

PRIMARY INSURANCE PLAN: EMPLOYER:_______________

INSURANCE COMPANY:_______________PHONE #:_______________

EMPLOYEE NAME:_______________DATE OF BIRTH:_______________

ID#:_______________GROUP #:_______________

SECONDARY INSURANCE PLAN: EMPLOYER:_______________

INSURANCE COMPANY:_______________PHONE #:_______________

EMPLOYEE NAME:_______________DATE OF BIRTH:_______________

ID#:_______________GROUP #:_______________

OTHER PLAN: Check if services covered by: ___STAR program ___CPS

Printed name of person completing form:_______________ Relationship to client:_______________

▶ Signature of person completing form:_______________ Date:_______________ *rev 06/18*