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ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Patient Name ____ **Today's Date** ___________________

Parent/Guardian Name(s) ____

Address ____

City __________________________________ **State** ______ **Zip Code**_________________________________

Please indicate if it is okay to leave a message by circling yes/no following each number listed

Home Phone_____________**yes no Cell Phone**_____________ **yes no Work Phone**____________ **yes no**

E-mail Address ____

Age_____ **Date of Birth** _______________ **Sex** _______ **Social Security #** ____________________________

Grade/School ____ **Is there an IEP at school** _______

Parent Occupation/Employer ____

Parent Occupation/Employer ____

Were you referred to this practice? Yes No By____

Medical Conditions and/or current medications and/or allergies _____________________________________

____

____

Has this child had previous counseling? Yes No Where/When/What Reason/How Long _____________

____

____

Have you ever been hospitalized for mental illness or substance abuse? Yes No If yes, for what specific reason?

____

____

Name of other persons living in your home **Relationship** **Age**

____ ____________ ______

____ _____________ ______

____ ______________ ______

____ ______________ _______

Emergency Contact: Name, Phone # and relationship to you ____

____

Please describe in your own words the current situation that led you to counseling (meaning the last two weeks): ____

____

____

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____

Please give a brief statement about what would have to happen for you to feel like counseling was helpful to you. Describe how your life would change. ____

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Please share any other information that you feel is important that is not covered above: _______________

____

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I certify that the above information is accurate.

Signature ____ **Date** ________________________________