



CHILD/ ADOLESCENT CLIENT INTAKE INFORMATION FORM

CARE & COUNSELING CENTER of Georgia

Counselor _____

Client # _____

Date _____

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

GENERAL INFORMATION - Please print!

Last name _____ First name _____ Middle initial _____

Birth date ____/____/____ Age _____ Male Female SSN: ____/____/____

Street address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

School attending _____ Grade _____

Employment (if applicable) _____

How did you hear about us? Clergy M.D. Brochure Family/Friend Internet Insurance

Referred by _____ Other

Reason you are coming for counseling: _____

Child's religious/denominational preference _____

Child's racial/ethnic identity: African-American Native-American Asian-American
 White/Caucasian Hispanic Other _____

FAMILY INFORMATION

Child's parents are Single Married/Partnered Divorced Date: ____/____/____ Widowed

Mother's name _____ Birth date ____/____/____ Age _____

Home phone _____ Cell phone _____ SSN: ____/____/____

Employer _____ Work phone _____

Father's name _____ Birth date ____/____/____ Age _____

Home phone _____ Cell phone _____ SSN: ____/____/____

Employer _____ Work phone _____

Others living in child's home (Names/Relationship to child/age) _____

Legal custodian (if applicable) _____

In case of emergency, contact _____

Relationship _____ Emergency phone _____

PAYMENT METHOD Authorization # _____ Dx _____

Responsible party & address _____

Primary insurance carrier _____

Street address _____

City _____ State _____ Zip _____ Phone _____

Policy # _____ Group# _____ Preauthorization required? Yes No

Insured's name _____ Relationship to client _____

Secondary insurance carrier _____

Street address _____

City _____ State _____ Zip _____ Phone _____

Policy # _____ Group# _____ Preauthorization required? Yes No

Insured's name _____ Relationship to client _____

Parent's Authorization

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

I hereby authorize payment directly to Care and Counseling Center of Georgia of any benefits due me 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 & phone number: _____

Has your child received psychotherapy or counseling in the past? Yes No When? _____

Counselor's name _____

Have you or any member of your family received help for drug or alcohol dependency?

Yes No When? _____ Where? _____

TREATMENT PLAN

(To be completed in session with your therapist)

Type of therapy: Individual Marriage/Couple Family Group

Frequency: _____

Treatment Goals: _____

Referrals (specify): _____

Client's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

Therapist's Credentials: _____