CHILD / ADOLESCENT CLIENT INTAKE INFORMATION FORM

HIGH POINT FAMILY THERAPY SERVICES

Office Use Only

Client #_____ Ins Dx_____
Therapist _____ Ther#___Loc_____

Today's Date _____

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

GENERAL INFORMATION – *Please print*

Name: Last_____ First _____ MI ____

Birth date ___/___/___ Age ____ ☐ Male ☐ Female Social Security Number _____-_____-_____

Street Address _____
City_____ State _____ Zip Code_____
Home phone _____ Cell phone _____
School attending _____Grade_____
Employment (*if applicable*) _____
How did you hear about us? ☐ Clergy ☐ M.D. ☐ Brochure ☐ Family/Friend ☐ Internet ☐ Insurance
☐ Therapist ☐HPFTS Client Referred by: _____
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 High Point Family Therapy Services, PLLC.

_____
Signature Date

I hereby authorize payment directly to High Point Family Therapy Services, PLLC of any Benefits due me 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 and dosages _____

_____

Child's Psychiatrist's name & phone number _____

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

Have you or any other family member received help for drug or alcohol dependency?
☐ Y ☐ N 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_____

Therapist's Credentials _____