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Date of intake_____ Insurance___/FFS___Who present:_____

Client name (if client is a child, use child's information):

Date of Birth_____ Address:_____

City_____ State_____ Zip_____

1.Guardian name (if applicable)_____Rx with child_____

Phone_____ Email_____

2. Guardian name _____Rx with child_____

Phone_____ Email_____

Other relevant contacts:_____

Client main referral
issue/s:_____

If there is a separation, please check appropriate description:

_____Married to child's parent. _____Divorced from child's parent
_____currently partnered, not married

_____previously partner with child's parent/not married

_____ Re-married _____Raising grandchildren.

_____Child was Adopted. (Date _____)

If child's parents do not live in the same home please note:
Who has legal custody? _____

Who has physical custody?_____/Share Physical custody

Is there a stipulation in your decree that states both parents must agree on mental health decisions? Yes/ No. If yes, please provide documention.

Payment Information (if using insurance)
Insurance Name:_____

Policy Holder_____Policy's holders DOB_____

Group number_____ ID #_____

Customer Service phone number listed on insurance card:_____

Do you know what your deductible is?_____

Do you have a co-pay per visit?_____ If yes, what is it?_____