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Client Name: D.O.B:

Parent/Guardian Name:

Street Address: City/Town:

State: Zip Code:

Home Phone: Cell Phone:

E-mail Address:

School Name (if applicable): City/Town:

State:

Name of Primary Doctor/Pediatrician:

Psychiatrist:

Referred for Mental Health Services By:

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Insurance Carrier: Card #:

Group #:

Name of Insured (parent/guardian, if minor):

Parent/Guardian D.O.B.:

Employer:

Insured (parent/guardian address) if different from above address:

Street Address: City/Town:

State: Zip code:

Reason for Visit/ Concerns:

Client Strengths/ Interests:

Additional Information (Psychiatric testing, IEP, 504 Plan, Community Supports):

Current Client Diagnosis, if known:

Current Medications:

Current/ Past Mental Health Treatment:

Past Hospitalizations (if yes, please note dates):

Known Medical Conditions:

Substance Use/ Abuse:

Other Current “At Risk” behaviors (family stressors, cutting, suicidal thoughts, truancy, court involvement):