COUNSELING LAS CRUCES

Child/Adolescent Patient Intake Form

Please complete this form

PLEASE USE INK
Today's Date: _____

How did you hear about us?
Web_____Doctor_____Friend_____Other_____

Information about your child

Name: _____ Social Security # _____-___-_____
Date of Birth: ____-____-_____ Age: _____ Sex: Male ____ Female ____Other_____
Address: _____
Home Phone: _____
Email address_____
City: _____ State: _____ Zip: _____
School: _____ Grade: _____ Special Education ☐ YES ☐ NO
Emergency contact_____ Relationship_____Telephone_____

Information about Mother

Name: _____ Social Security # _____-_____-_____
Date of Birth: _____-_____-_____ Age: _____ Sex: Male _____ Female ____Other_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email address: _____
Occupation: _____ Employer: _____
Marital Status: Single __ Married __ Divorced __ Cohabitate __ Widowed __

Information about Father

Name: _____ Social Security # _____-_____-_____
Date of Birth: _____-_____-_____ Age: ____ Sex: Male ____ Female ____Other_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email address_____
Occupation: _____ Employer: _____
Email address: _____
Marital Status: Single __ Married __ Divorced __ Cohabitate __ Widowed __

Other people living in the child's primary home

(use the back of this form if you need more space)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Insurance Information

Primary Insurance Company: _____Auth.#_____

Insured's Name: _____ DOB: ___-___-____

Social Security/ID# _____ Group# _____

Secondary Insurance Company: _____Auth.#_____

Insured's Name: _____ DOB: ___-___-____

Social Security/ID# _____ Group# _____

Medical Information

Doctor's name: _____ Phone # ___ _____

Address: _____ City: _____ State: ____ Zip: _____

May I contact your child's doctor so that we can coordinate care? ☐ Yes ☐ No

Does your child have any serious medical conditions? ☐ Yes ☐ No If yes, please describe:

_____

_____

Please list all medications (over-the-counter and prescription) and their dosages that your child is currently taking:

_____	_____
_____	_____
_____	_____

Please list all allergies to medications or food that your child has:

_____	_____
_____	_____
_____	_____

Treatment Information

Why are you seeking counseling for your child now? _____

_____

Who referred you to us for counseling? _____

Has your child ever experienced any of the following?

Alcohol/drug abuse ☐ Yes ☐ No Physical abuse ☐ Yes ☐ No

Suicide attempt ☐ Yes ☐ No Sexual abuse ☐ Yes ☐ No

If yes to any of the above, please briefly explain: _____

_____

_____

_____

Has your child been in counseling before? ☐ Yes ☐ No If yes:

With whom/when: _____

For what reason: _____

Has your child been hospitalized for psychiatric reasons? ☐ Yes ☐ No If yes:

Where/when: _____

For what reason: _____

PARENT'S OR AUTHORIZED PERON'S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims (☐ YES ☐ NO) and I authorize payment of medical benefits to Counseling Las Cruces for services rendered (☐ YES ☐ NO).

SIGNED: _____ DATE: _____