Arbor Counseling

208 West Pointe Drive, Suite B   Swansea, IL 62226

Client Information - Child **Today's date**: ______________________________

Your Child's Name: ______________________________ Date of Birth: ____________________ Age:____

Home street address: ____ Apt.:____________________

City: ______________________________________ State: ____________Zip: ________________

Best contact phone: ______________________ Can we leave a message at this number? YES NO

Father: ______________________________ Employer: ______________ Date of birth____________

Address: ____

Street Suite# City State Zip

Work phone: __________________________ Can we leave a message at this number? YES NO

Cell Phone: __________________________ Can we leave a message at this number? YES NO

Mother: ______________________________ Employer: ______________ Date of Birth____________

Address: ____

Street Suite# City State Zip

Work phone: __________________________ Can we leave a message at this number? YES NO

Cell Phone: __________________________ Can we leave a message at this number? YES NO

Payment Information

Primary Policy Holder Name: ______________________________ Relationship to Child:________________

Primary Policy Holder's Date of Birth: ______________________ Employer______________________________

____

Insurance Company Member ID #. Group or Policy #.

____

Billing Address Phone Employer

____

Secondary Insurance Company Member ID #:. Group or Policy #

____

Billing Address Phone Employer

Referral: Who gave you my name to call?

Name: ____ Phone: __________________________

Address: ____

May I have your permission to thank this person for the referral? • Yes • No

How did this person explain how I might be of help to your child? ______________________________

____

____

Guardian Signature Date

Arbor Counseling

Brief Health Information Form (Child)

Identification

Child's name: ____ Date: ____________________

Health History

Starting with birth and proceeding up to the present, list all diseases, illnesses, significant accidents and injuries, surgeries, hospitalizations, convulsions/seizures, and any other medical conditions your child has had.

Age of Onset	Illness/diagnosis	Treatment received	Treated by	Outcome

Describe any allergies your child has.

To what?	Child's Reaction to allergen	Allergy medications

List all medications or drugs your child takes or has taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

Did the mother experience any difficulties during pregnancy with this child, or during the delivery? ______________

____

What are your primary reasons for seeking counseling?

____

____

Child's Primary Care Physician (Name, Address & Phone)

____

____

____

•

____

Please check the appropriate box below:

May I have your permission to inform him/her of your involvement in counseling? • Yes • No

May I have your permission to discuss with your physician any treatment concerns, evaluations, needs and/or progress? Yes • No

____

Guardian Signature Date

I acknowledge that I am familiar with my privacy rights through HIPPA, and understand that if I have any questions or wish to receive a written copy of this office's privacy policy, I can ask my child's therapist for one.

Signature and Date ____