**C**ounseling & **P**sychology **R**esources

A CENTER FOR COUNSELING AND PSYCHOLOGICAL HEALTH CARE Gary S. Indenbaum, Ph.D., LP

## CLIENT QUESTIONNAIRE - CHILDREN & ADOLESCENTS

Today's date: _____

Child's Name: _____Date of Birth: ___/___/____ Age: _____
Child's Social Security #: ____ - ____ - _____
Phone: Primary: _____ Secondary: _____
Primary Address: _____
City: _____ State: _____ Zip: _____
Person Completing Form: _____ Relationship: _____
Parent's Names Mother: _____ SSN: _____
Father: _____ SSN: _____
Please Circle One: Married Separated Divorced

Employers Mother: _____Phone:(____)_____
Father: _____Phone: (____)_____
May We Contact You At Work (M) YES/NO (F) YES/NO Please Circle One Each

Grade: _____ School: _____
Teacher's Name: _____
Child's Pediatrician or Family Physician: _____
Who Referred You to Our Office? _____
Reason for Referral: _____
_____

Has Child Had Previous Psychological Counseling: YES NO
If Yes, Please Explain: _____
_____
_____
List Any Medications Child Is Currently Taking: _____
_____
List All Immediate Family Members:

| Name | Age | Relationship | Occupation |
|---|---|---|---|
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**In the event of an emergency, who should we contact other than Mother or Father:**
**Name:** _____ **Relationship:** _____
**Phone:** _____

**Continued…**

## Agreement for Counseling or Psychological Services

I, _____, the parent/legal guardian of _____, agree to keep all scheduled appointments and understand that 24-hour notice is required for cancellation. I agree to pay for appointments that are not cancelled within 24 hours unless a legitimate emergency occurs. I understand and accept that I am fully responsible for all charges and that all fees or co-pays are due at the time the service is provided unless other arrangements have been made. *Please remember, in most cases, your insurance carrier has an agreement with you, not our office, to assist with payment of your health care costs. We strongly encourage you to contact your carrier directly concerning your outpatient mental health or other health care benefits.*

I understand that necessary information will be provided to my insurance carrier, in order to process any claim made for services.

My signature below means that I understand and agree with all points above.

_____ _____

Signature of Parent/Legal Guardian Date

## Referral Release Form

Our office would like to extend our appreciation and communicate with your physician or other professional that referred you to our office. Your signature below authorizes us to do so.

Name of Referring Professional (e.g. Physician or Attorney):

_____

Address:

_____

_____

_____

Signature of Parent/Legal Guardian:

_____

Date: