Rebecca Tillemans, MS LCPC

CONFIDENTIAL CLIENT INFORMATION
CHILD/ADOLESCENT

Client Name: _____ Intake Date:_____

Address: _____ Date of Birth: _____

City: _____ State: MD Zip:_____ School: _____

Mother's Name: _____ Father's Name: _____

Child lives with: (circle one) Both Parents Father Mother Other:_____

Second Parent Address
_____

City:_____ State: MD Zip:_____ Referred by: _____

Contact Information

Client: Home _____ School_____ Cell_____

Mother: Home _____Work_____ Cell_____

Father: Home _____Work_____ Cell_____

Email: _____

Physician Name _____ Office number _____

School Contact: _____ Office number_____

I understand that unless other arrangements are made, all fees are due at the time of service. I agree to accept financial responsibility for all charges, including missed appointment fees with less than 24 hours notice. I authorize the release of any information necessary to process my insurance claims with my carrier. Any statement balance billed is due and payable upon receipt of a finance charge of 1.5% will be added monthly to the unpaid balance until the debt is fulfilled.

Guarantor: _____ Relationship to child:_____

Guarantor/Parent Signature:_____Date:____/_____/_____

If you'd like me to keep a credit card number on file, please fill in the following:

Card Type:_____

Card Number:_____ Exp Date: _____

Client Intake Child/Adolescent -- Page two

Is your child currently receiving treatment for a medical condition? Yes ___ No___ If yes, please explain:

_____

_____

Has your child had prior psychotherapy, mental health or substance abuse counseling? Yes___ No___ If yes, please indicate when and with which provider(s): _____

_____

Please indicate any Psychoactive Medications your child is currently taking:

_____

Please indicate any other medications or supplements your child is taking, and for which condition:

_____

_____

Please indicate which of these issues are concerning you and your child today:

____ Depression, unhappiness
____ Anxiety, worry, nervousness
____ Panic attacks
____ Phobia(s)
____ Perfectionism
____ Anger Management problems
____ Grief, loss
____ Trauma
____ Mood swings
____ Irritability
____ Lack of assertiveness
____ Sleep problems
____ Appetite problems
____ History of abuse
____ Few friends, loneliness
____ Social skill problems
____ Anger management
____ Alcohol or substance abuse
____ School performance problems
____ School behavior problems
____ Memory difficulties
____ Disorganization
____ Difficulty concentrating
____ Procrastination
____ Time management problems
____ Conflicts with parents
____ Body image concerns
____ Excessive video game use

Please indicate any other concerns or give additional information that you think would be helpful:

_____

_____