DAEMION
COUNSELING CENTER

DATE: _____

ADOLESCENT INTAKE FORM

UNDER 18 YEARS OLD

This information is intended to assist our staff in working with you toward your goals of therapy. If you have any concerns about answering these questions, we encourage you to discuss them in person with our staff.

Information you provide here is protected as confidential with two exceptions: 1) All therapists and counseling office staff are mandated to report suspected child abuse or neglect, including information about yourself or children in your care, as well as information you may tell us about any physical, sexual, psychological, or emotional abuse of a minor by another individual. 2) We are mandated to take action if we believe you are a harm to yourself or to others.

Client Name: _____
(First) (Middle Initial) (Last)

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

May we send mail to the above address? □ Yes □ No

Cell/Other Phone: _____ May we leave a message? □ Yes □ No

Home Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____

May we email you regarding counseling related correspondence? □ Yes □ No
May we email you with occasional updates or information? □ Yes □ No

Please note:** ***Email correspondence is <u>not</u> considered to be a confidential medium of communication.

Birth Date: ____ /____ /____ **Age**: _____ **Gender**: □ Male □ Female □ Other: _____

Last 4 digits of your social security number: XXX-XX- _____

Name of parent/guardian: _____
(First) (Middle Initial) (Last)

Client Ethnicity: (*This information will be used for classification purposes only)*
□ African American (not of Hispanic origin) □ Asian or Pacific Islander
□ Hispanic □ Native American or Alaskan Native □ White/Caucasian
□ Bi/Multi-racial □Other:_____

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Parent Marital Status:

□ Single, never married □ Married □ Separated □ Divorced/Single
□ Divorced/Remarried □ Widow/Widower □ Domestic Partnership

How did you hear about us?

□ Parent/relative □ Court/Police □ Friend □ School □ Online
□ Insurance □ Agency □ Post Card □ Professional
□You're a returning client □ From someone who is/was a client

Name of referral source: _____

Have you served in the military? □Yes □No
Has a loved one (family or friend) ever served in the military? □Yes □No

EMERGENCY CONTACT INFORMATION

By providing this information, you are giving us permission to call if there is an emergency.

Name: _____ Relationship: _____

Local phone number: _____

ADDITIONAL INFORMATION

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation? _____

2. Are you currently a student? □ No □ Yes
If yes, what is your current school name? _____

Household Size
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ Other: _____

Annual Gross Household Income
- ❑ Up to $15,000
- ❑ $15,001 to $30,000
- ❑ $30,001 to $40,000
- ❑ $40,001 to $50,000
- ❑ Over $50,000

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Do you have medical insurance? ☐ Yes ☐ No

If Yes, Provider: _____

If paying with one of the insurances we currently accept, you will be asked to provide us with a **copy of your insurance card** and to complete an Acknowledgement of Financial Responsibility Form. Please note: if we do not accept your insurance and you intend to file for reimbursement with your insurance, you must notify us so we will ensure you are seen by a licensed therapist.

GENERAL PHYSICAL HEALTH AND WELLBEING INFORMATION

1. **Current physical health, including specific health concerns, diagnoses, or treatment:**

_____

_____

2. **Current prescription medications:**

_____

_____

3. **Date of last medical exam**: _____ Family doctor: _____

Phone: _____ Address: _____

4. **Current sleeping habits, including specific sleep concerns:**

_____

_____

5. **Current chronic pain you are experiencing:**

_____

_____

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6. **Current exercise and physical activities:**

_____

_____

7. **Current appetite or eating patterns, including specific eating concerns:**

_____

_____

By signing below, I certify that all of the information provided within this form is true and correct to the best of my knowledge.

_____ _____

Client Signature **Date**

FOR OFFICE USE ONLY: Client #: _____ Classification: _____

Assigned Fee: _____ Counselor Assignment: _____

Note to Therapist: If client is paying with insurance, client **must** complete Acknowledgement of Financial Responsibility form **AND** Request/Authorization to Release Confidential Records and Information.