



PIONEER COUNSELING CENTER

CLIENT INFORMATION PACKET (CHILD)

Client Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Present Employer: _____

Primary Phone # (to confirm appts): () _____ Circle Type: Home / Cell / Work

Secondary Phone #: () _____ Circle Type: Home / Cell / Work

Check Box (es) if you **DO NOT** want: Confirmation Calls Any Phone Contact

Social Security # for billing purposes: ___/___/___ Marital Status: _____

Sex: Male Female Who referred you to us? _____

Whom should we contact in case of emergency? Name: _____

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

Relationship? _____ Home #: _____ Work #: _____

If your insurance is an HMO or requires prior authorization, did you call for prior authorization? YES NO*

*If NO, you must call immediately and inform you therapist/doctor.

Please complete the insurance information and give the receptionist your insurance card to COPY

Primary Insurance:

Name of Insurance Company: _____ **Date of Birth of Policy Holder: _____

Name of Policy Holder: _____ **Policy Holder's Social Security #: _____

Contract #: _____ Group#: _____ Policy Holder's Employer: _____

Relation to Policy Holder: Self Spouse Dependent

Do you have any other health insurance? NO YES

Secondary Insurance:

Name of Insurance Company: _____ **Date of Birth of Policy Holder: _____

Name of Policy Holder: _____ **Policy Holder's Social Security #: _____

Contract #: _____ Group#: _____ Policy Holder's Employer: _____

Relation to Policy Holder: Self Spouse Dependent

Do you have any other health insurance? NO YES



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CHILD AND ADOLESCENT PERSONAL HISTORY

Child's Name: _____ Social Security #: _____

Birth date: _____ Person Completing Form: _____

Relationship to child: Mother Father Guardian Other (explain) _____

Reason child is coming for treatment: _____

How does your child feel about treatment: _____

SCHOOL ADJUSTMENT

Name of school: _____ School District: _____

What grade is your child in? _____ Has he/she ever repeated a grade? YES NO If yes, what grade?

Grade: K 1 2 3 4 5 6 7 8 9 10 11 12

What sort of grades is your child earning? _____

Please describe any learning disabilities you child is experiencing: _____

Has your child been psychologically tested? NO YES If yes, when? _____ and where? _____

Has your child ever had special education services? NO YES Please explain: _____

Has your child ever worked? NO YES Where? _____

PERSONAL ADJUSTMENT Please circle any of the following that are typical of child's behavior.

- | | | | |
|---------------|--------------------|----------------------|----------------------|
| Shy | Frequent headaches | Psychiatric problems | Drug/alcohol use |
| Quarrels | Bizarre behavior | Angry, Defiant | Unusual thinking |
| Sleepwalking | Easy-going | Difficulty sleeping | Tics or twitches |
| Loner | Enthusiastic | Sad, cries | Careless, reckless |
| Destructive | Overactive | Lies frequently | Short attention span |
| Weight loss | Generous | Poor appetite | Frequent daydreams |
| Avoids adults | Sloppy Hygiene | Lazy | Speech problems |

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CHILD AND ADOLESCENT PERSONAL HISTORY

PERSONAL ADJUSTMENT (CONT) Please circle any of the following that are typical of your child's behavior.

- | | | | |
|-------------------|-----------------------|-------------------|-------------------|
| Frequent injuries | Often ill | Worries | Stomach aches |
| Slow moving | Police problems | Bullies | Blinking, jerking |
| Moody | Messy | Bedwetting | Friendly |
| Temper tantrums | Seizures | Expects failure | Confident |
| Soiling | Learning problems | Steals | Cooperative |
| Selfish | Acts without thinking | Overweight | Clumsy |
| Sets Fires | Suicide gestures | Sexual acting out | Suicide attempts |

CHILD'S FAMILY HISTORY

Relationship	Name	Age	Sex	Education	Employed	Living in home
Father						
Stepfather						
Mother						
Stepmother						
Sibling(s)						
Others in Home:						

How does your child relate to family members? _____

Was your child adopted? NO YES At what age? _____ Does your child know? NO YES

Who is the legal guardian? _____

TREATMENT HISTORY

Has your child ever been in: Outpatient treatment? No Yes If yes, when? _____

Where? _____ Inpatient treatment? No Yes If yes, when? _____

Where? _____

Have any family members ever been in: Outpatient treatment? Yes No If yes, when? _____

Where? _____ Inpatient treatment? No Yes If yes, when? _____

Where? _____

SUBSTANCE ABUSE HISTORY

Does your child have a problem with alcohol or drugs? No Yes

Any tobacco use? No Yes Amount: _____ Caffeine use? No Yes Amount: _____

Substance Used? _____ Age of first use? _____

Frequency Used? _____ Date of last use? _____ Number of days used in the last month? _____

RELIGION

Any religious conflicts/concerns in the family? No Yes If yes: _____

Does your child practice? No Yes If yes, what religion: _____

INCOME DATA

Any financial problems? No Yes

Do both parents work? No Yes

LEGAL

Has your child even been involved with the police or juvenile court system? No Yes

If yes, please explain: _____

Are the parents currently involved in a divorce or custody issue? No Yes

If yes, please explain: _____

DEVELOPMENTAL HISTORY

Physical/Medical Complications during pregnancy with: Mother Child

Check any that were used during pregnancy: Tobacco Alcohol Drugs

Birth: Full Term Premature Weight: _____

Type of delivery: (e.g. breech, cesarean, normally): _____

What age did your child walk alone: _____, use single words: _____, sentences: _____

What age was your child potty trained? _____

Current language problems: _____

When was your child's last hearing exam? _____

When was your child's last eye exam? _____

Has your child ever had seizures? _____

Has your child experienced injuries, or hospitalization? No Yes

If yes, please explain: _____

SEXUAL HISTORY

Any sexual or gender concerns? No Yes

If yes, please explain: _____

Abuse History: Physical Abuse? No Yes If yes, at what age? _____

Sexual Abuse? No Yes If yes, at what age? _____

MEDICAL HISTORY

Child's Physician: Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Name of Preferred Hospital: _____

Immunization status: Are your child's immunizations current? No Yes

If no, please explain: _____

Date of child's last physical exam: _____ Results: _____

Is your child taking any medication? No Yes If yes, what? _____

Is your child allergic to any medications? No Yes If yes, what? _____

What would you like to have happen while your child is in treatment here? _____

Signature of the person completing the form: _____ Date: _____

FOR OFFICE USE ONLY

Treatment Coordination/Therapist & Credentials

Date

Physician's Recommendations: A physical exam is required A physical exam IS NOT necessary for treatment

Comments: _____

Physician Signature & Credentials

Date