Counseling and Development Inc
Jill Polisner, MA., Ed.S., LPC – 8470 Holcomb Bridge Road Suite 140 Alpharetta GA 20022
(P)770-314-0758 (F) 888-977-1266

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your child's name: _____
Last First Middle Initial

Parent or Legal Guardian's Name: _____
Last First Middle Initial

Child's date of birth: _____ **Gender:** _____

Parent or Legal Guardian's Social Security #: _____

Home street address: _____

City: _____ **State:** _____ **Zip:**_____

Parent or Legal Guardian's Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions:_____
_____

Referred by: _____
- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name Phone
We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature):_____

Please briefly describe your child's presenting concern(s):_____
_____
_____

What are your/your child's goals for therapy? _____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:_____
_____
_____
_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____
_____
_____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual
__Transgender __ Asexual __In Question __Other: _____

Racial/Ethnic Identity:
__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__White/European-American
__Not listed

FAMILY:

How would you describe your child's relationship with his or her mother?_____
_____
_____

How would you describe your child's relationship with his or her father?_____
_____
_____

Are the child's parents still married or did they divorce?_____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her? _____
_____

Please describe your child's relationship with his or her grandparents: _____
_____
_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _____
_____
_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?_____
_____
_____
_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

Child's current level of satisfaction with friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

How would you describe your child's relationships with his/her peers? _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

Please briefly describe your child's self-care and coping skills: _____
_____
_____

What are your child's diet, weight, and exercise/activity patterns?_____
_____
_____

Please briefly describe your child's school performance and experience:_____
_____
_____

What are your child's hobbies, talents, and strengths?_____
_____
_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				Tantrums →				Nausea →		
Depression				Parents Divorced				Stomach Aches		
Mood Changes				Seizures				Fainting		
Anger or Temper				Cries Easily				Dizziness		
Panic				Problems with Friend(s)				Diarrhea		
Fears				Problems in School				Shortness of Breath		
Irritability				Fear of Strangers				Chest Pain		
Concentration				Fighting with Siblings				Lump in the Throat		
Headaches				Issues Re: Divorce				Sweating		
Loss of Memory				Sexually Acting Out				Heart Problems		
Excessive Worry				History of Child Abuse				Muscle Tension		
Wetting the Bed				History of Sexual Abuse				Bruises Easily		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Makes Careless Mistakes		
Separation Anxiety				Hurting Self				Fidgets Frequently		
Alcohol/Drugs				Thoughts of Suicide				Impulsive		
Drinks Caffeine				Sleeping Too Much				Waiting His/Her Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Head Injury				Sleeping Alone				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____

_____

Primary Insurance Information and Benefit Verification Worksheet and Consent to Treatment

Patient Name_____

DOB of Patient _____SS# of Patient_____

Insurance Provider_____Effective Date_____

Policy Number_____Group Number_____

Name of *Primary* Insured (if different from patient)_____

Employer of *Primary* Insured _____

DOB of *Primary* Insured_____SS# of *Primary* Insured_____

Phone Number for Mental Health Services_____

Name of Insurance Rep with whom you spoke and date you spoke with them_____

Are Authorizations required? Yes No

Number of sessions authorized_____

Authorization Number(s)_____

CPT Code(s)_____

Start Date_____End Date_____

Copay_____Deductible_____

Has the deductible been met for this year? Yes No

Maximum Visits per Year_____

What is the specific address for Mental Health Claims (this address is usually different from the general

medical claims address on your insurance card)

_____

_____

_____

Counseling and Development Inc. is required by law to collect all co-pays at the time of service. There will be a $25.00 service charge for any unpaid/returned checks. Please note: we do not file secondary insurance unless required to do so by federal law.

If you have insurance that requires preauthorization, you must notify your clinician of any changes in your insurance coverage and benefits before each visit. It is your responsibility to ensure that your visits are fully authorized by your insurance company. By law, we cannot bill your insurance for missed appointments. You are responsible for the full payment of all appointments not cancelled with at least 48-hour notice.

I hereby authorize all information necessary for the purpose of authorizing and processing my claims to be released to my insurance company. I understand this information may include diagnoses, dates of service, charges, symptoms, and treatment recommendations. I understand that I am fully responsible for my bill and will assume any charges not paid by my insurance company. I understand that I will be charged $100.00 for any appointments not kept unless at least a FULL 48-HOUR notice (a 72-hour notice is required if cancellation is for a Monday appointment) is given to the clinician.

I consent for treatment necessary for the care of the above-named patient. I have read, understand, and agree to the office policies, attached.

Signature of Patient or Guardian

Date