Paris Counseling Center, PA

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Rev 06/18

CHILD Client Information

PLEASE COMPLETE ALL FOUR PAGES

CLIENT NAME: ____Date:_________________

Birthdate:___________________________Age:____________School:_______________________Grade:______

Address/City/State/Zip:____ SS#:______________________

PARENT/GUARDIAN #1:

NAME:_____________________________________ Relationship to Client _____________________________

Birthdate:_________________________________Age:____________SS#:______________________________

Address/City/State/Zip:____

Home Phone:_________________ | Work Phone:___________________ |Cell Phone:_____________________
May we call you at home? yes no | May we call you at work? yes no | May we call your cell? yes no
May we leave a message? yes no | May we leave a message? yes no | May we leave a message? yes no

Email address (for secure email communication):____

Appointment reminder preference: ___ Text ___Email ___Home Phone

Employer and Position:____ How long?_______________
Education level: ___Elementary ___High School ___Some College ___College Degree ___Grad Study
Marital Status: ___Single ___Married ___Live together ___Separated ___Divorced ___Widowed
Previous marriage(s)?:____

Religious/Church affiliation:____ ___Active ___Inactive

PARENT/GUARDIAN #2:

NAME:______________________________________ Relationship to Client_____________________________

Birthdate:_________________________________Age:____________SS#:______________________________

Address/City/State/Zip:____

Home Phone:_________________ | Work Phone:___________________ |Cell Phone:_____________________
May we call you at home? yes no | May we call you at work? yes no | May we call your cell? yes no
May we leave a message? yes no | May we leave a message? yes no | May we leave a message? yes no

May we communicate with you by email if necessary? If so, give address:________________________________

Employer and Position:____ How long?_______________

Education level: ___Elementary ___High School ___Some College ___College Degree ___Grad Study
Marital Status: ___Single ___Married ___Live together ___Separated ___Divorced ___Widowed
Previous marriage(s)?: ____
Religious/Church affiliation:____ ___Active ___Inactive

If parents are not married, who is the court-designated managing conservator?__________________________
We will need copy of court document designating conservatorship.
Name of stepfather:____________________________________ How long married to mother? _____________
Name of stepmother:___________________________________ How long married to father? _______________

PERSONAL / FAMILY HISTORY: ***IF AN ISSUE DOES NOT APPLY, PLEASE MARK "N/A"***

SIGNIFICANT MEDICAL ISSUES OF CLIENT AND FAMILY MEMBERS:

Who	*Condition*	*Dates*	*Physician / Location*

PREVIOUS COUNSELING / THERAPY OF CLIENT AND FAMILY MEMBERS:

Who	*Reason*	*Dates*	*Counselor / Location*

PREVIOUS PSYCHIATRIC DIAGNOSES GIVEN OF CLIENT AND FAMILY MEMBERS:

Who	*Diagnoses*	*Dates*	*Physician / Location*

HOSPITALIZATION FOR PSYCHIATRIC CONDITIONS OF CLIENT AND FAMILY MEMBERS:

Who	*Reason*	*Dates*	*Physician / Hospital*

MEDICATIONS PRESCRIBED FOR PSYCHIATRIC CONDITIONS OF CLIENT AND FAMILY MEMBERS:

Who	*Medication/Dosage/Frequency*	*Date*	*Reason*	*Has it helped?*	*Physician*

HISTORY OF SUBSTANCE ABUSE FOR CLIENT & FAMILY MEMBERS: *(alcohol, illicit drugs, prescription drugs)*

Who	*Substance*	*Age/date started?*	*Age/date last time used?*	*Treatment?*

HISTORY OF ABUSE OF CLIENT: *(physical, mental/emotional, sexual)*

Type of abuse	*Dates / age*	*Perpetrator*	*Outcome*

HISTORY OF LEGAL PROBLEMS *(do not list traffic citations)***:**

Who	*Charge*	*Date*	*Arrested?*	*Conviction?*	*Outcome*

PRIMARY PHYSICIAN OF CLIENT: ____

When last seen___________________________ Reason ____

PERSONAL CONCERNS: *Please place a check mark next to the client's concerns.*

Depression	Anger	Alcohol/drug use	Sleep problems	Physical abuse	School performance
Anxiety/Worries/ Fears	Temper tantrums	Sexual activity	Bad dreams	Sexual abuse	Poor attention
Moodiness/ Unhappiness	Fighting	Lying	Bedwetting	Verbal/Emotional abuse	Hyperactivity
Complaining	Arguing	Stealing	Eating disorder	Relationship with parent	Immaturity
Shyness / Self-esteem	Manipulative behavior	Running away	Health problems / allergies	Relationship with stepparent	Other _______________
Jealousy	Disobedience	Impulsivity	Sexual concerns	Visitation arrangement	Other _______________

Why are you seeking help at this time?____

____

____

What do you wish to accomplish through counseling? _______________________________

____

____

____

____

____

____

FAMILY MEMBERS: *please list all members of your household* (If more space is needed use bottom of page 4)

Name ***Relationship*** ***Age*** ***Birthdate*** ***School*** ***Grade***

1.____

2.____

3.____

4.____

5.____

Please list other siblings who are living outside of your home:

Name ***Relationship*** ***Age*** ***Birthdate*** ***School*** ***Grade***

1.____

2.____

Name of nearest relative **not** living with you:_________________________________ May we contact? yes no

Address;____Phone:__________________Relationship:_________

Who to contact in case of emergency:____ Relationship:________

Address:_____________________________________ Home Phone:____________ Work phone:___________

Were you referred here by anyone? YES NO If so, who?____

Please indicate any individual(s) you may want us to confer with during the course of your therapy, (i.e. physician, spouse, parent, child(ren), etc. If you are taking medication, it is often helpful to consult with the physician who prescribed your medicine. Your signature authorizes two-way consultation with the persons listed and releases your therapist and Paris Counseling Center, P.A. from liability resulting in the release/obtaining of information.

Name(s):____Relationship:_________________

Name(s):____Relationship:________________

► Signature:_______________________________________

CLIENT INSURANCE INFORMATION (MUST BE COMPLETED)

EMPLOYEE ASSISTANCE PROGRAM: *(If you will be using the benefits of an employee assistance program, please complete this information. If not, please skip to Primary Insurance Plan.)*

EAP COMPANY:____PHONE #:___________________

EMPLOYER:____

EMPLOYEE NAME:____DATE OF BIRTH:________________

Have you spoken with the EAP company? ___yes ___no *(EAPs generally require the client to call and authorize.)*

Did they authorize sessions? ___yes ___no How many?_______ Authorization #:____________________

PRIMARY INSURANCE PLAN: EMPLOYER:____

INSURANCE COMPANY:____PHONE #:__________________

EMPLOYEE NAME:____DATE OF BIRTH:_______________

ID#:____GROUP #:____________________________

SECONDARY INSURANCE PLAN: EMPLOYER:____

INSURANCE COMPANY:____PHONE #:__________________

EMPLOYEE NAME:____DATE OF BIRTH:_______________

ID#:____GROUP #:____________________________

Printed name of person completing form:_________________________ Relationship to client:_____________

► Signature of person completing form:________________________________ Date:____________________