JOHN C. HOUTON, PhD LPC CAADC

"Help & Hope for Children and Families"
32 S. 10th Street, Akron, PA. 17501
Phone: 717-341-6004 • Fax: 717-859-5674

Intake Form

Client Information:

Client's Name _____ Date of Birth _____

Client's SS# _____ Client's Gender ____ Custody Status _____

Client's School _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____ E-mail _____

Parent/Guardian Information:

Parent(s) Name _____

* If different from client
Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____ E-mail _____

Other Information:

Emergency Contact _____ Phone Number _____

Presenting Problem (reason for seeking services) _____

_____

Previous therapeutic services? Yes ____ No ____

If yes, where? _____

Presently taking psychotropic medication? Yes ____ No ____

If yes, name(s) of medication _____

If yes, prescribed by whom? _____ Duration? _____

Have any evaluations been completed? Yes ____ No ____

If yes, what type? _____

When? _____ By whom? _____

Referral Source? _____

Family Information:

Name _____ DOB _____ Relationship to client _____

Name _____ DOB _____ Relationship to client _____

Name _____ DOB _____ Relationship to client _____

Name _____ DOB _____ Relationship to client _____

Name _____ DOB _____ Relationship to client _____

Name _____ DOB _____ Relationship to client _____

Signatures:

PRIMARY CLIENT, PLEASE SIGN HERE. If primary client is a minor, parent/guardian must sign. I hereby give consent to ICF to provide assessment and/or treatment to my minor child or me.

Signature _____ Date _____

NOTICE: Full payment is expected at time of service. We will provide information for you to submit to your insurance company. We have no contracts with insurance companies and are an out-of-network provider. I will provide full payment at time of service.

Signature _____ Date _____

INTEROFFICE INFORMATION RELEASE. If primary client is a minor, parent or guardian must sign. I understand that all clinical records may be reviewed by ICF's clinical supervisor, a licensed psychologist, at any time. If necessary, I agree that clinical records may be shared within this office only by professional staff.

Signature _____ Date _____