Stress Management Family Counseling Center
300 Boardwalk Drive, Building 5-A
Fort Collins, CO 80525

PATIENT INFORMATION - ADOLESCENT (12+)

Personal Identification

Name: _____Date: _____/_____/_____
DOB: _____/_____/_____ Gender: _____ Pronoun (optional): _____
Address: _____
City: _____ State: _____ Zip code:_____
E-mail: _____ May we email you (Y/N)? _____
May we: call? (Y/N) leave message (Y/N)?
Telephone: Home: _____ _____ _____
Mobile:_____ _____ _____
Occupation: _____
School: _____Grade:_____
Parent/legal guardian*: _____ Telephone #: _____
Address (if different):_____
Parent/legal guardian*: _____ Telephone #: _____
Address (if different): _____
Siblings (name and age) _____
_____

Billing information

Please check one: ( ) self-pay ( ) Insurance ( ) other: explain_____
Responsible party for payment _____ Telephone: _____
Insurance company to be billed _____ Group #_____
Primary insured's name: _____ ID # _____
Primary insured's employer: _____
Primary insured's date of birth: _____/_____/_____ Social security # _____

Treatment information

Referred by: ( ) physician ( ) friend ( ) social media ( ) EAPs ( ) insurance ( )SMFCC website
( ) other (list) _____
Describe the nature of the problem that brought you here today: _____
_____
_____
Family physician:_____
List of medical problems:_____
_____
List of medication (if any): _____
_____
Previous mental health treatment ( )Yes ( ) No
Name of therapist, date seen and problem:_____
_____

Relative or friend we may contact in case of emergency
Name: _____ Telephone # _____
Do your parents/legal guardian authorize this treatment?(Y/N)_____ May we contact them? (Y/N)_____
Who completed this intake form? _____
Relationship to the client:_____

* Please, underline the description that best represents the relationship.