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

PATIENT INFORMATION - CHILD

Personal Identification

Name: _____Date: _____/_____/_____
DOB: _____/_____/_____ Sex: _____
Address: _____
City: _____ State: _____ Zip code:_____
May we: call? (Y/N) leave message (Y/N)?
Telephone: Home: _____ _____ _____
Mobile:_____ _____ _____
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:
_____
_____
Describe relevant development milestones: _____
_____
_____
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 # _____

Who completed this intake form? _____
Relationship to the client: _____

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