

Clarissa J. Hill M.A., LMHC

Welcome to my practice. I look forward to working with your child. This form requests information about your child that will help me begin to get to know him or her. It also confirms your consent that your child receives treatment. Please take a few moments to complete both sides of this form. These questions are designed to help me best meet your child's treatment needs. If you have any questions, I will be happy to answer them.

Client name _____ Birth date _____

Address _____ Age _____

City, State, Zip _____ Gender _____

OK to send mail here? Y N

Phone Numbers (____) _____
Home OK to contact there? Y N OK to leave msg there? Y N

(____) _____
Mobile OK to contact there? Y N OK to leave msg there? Y N

E-mail address (optional) _____

Please note that email is not a secure or confidential mode of communication

Mother's name _____

Mother's phone _____

Relationship Status Single Married Domestic Partner Separated Divorced Widowed

Father's name _____

Father's phone _____

Relationship Status Single Married Domestic Partner Separated Divorced Widowed

Primary Guardian's name _____

Primary Guardian's phone _____

Relationship to client _____

Primary Care Physician _____ (____) _____
Name Phone number

Emergency Contact _____ (____) _____
Name Relationship to client Phone number

Please list other persons living in your household(s) and their relationship to your child:

Please describe your reason(s) for seeking treatment for your child at this time. If there is a particular event which triggered your decision, please list the event:

What result(s) do you expect from treatment?

Has your child ever received mental health treatment before? If so, please list dates, provider name, and the reason for seeking treatment:

Please list any medications your child is currently taking:

CONSENT: I have read the OFFICE POLICIES AND CLIENT TREATMENT AGREEMENT and have received a copy of this information. I have clarified any questions I have and understand the information. I agree to the stated terms and hereby give permission for treatment of the above stated client.

Signed: _____
Parent or Legal Guardian

Date: _____

Relationship to client: _____

Signed: _____
Clarissa Hill, LMHC

Date: _____