Pathways to Growth Counseling

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Important information in order for me to work with you:

Child's Name: _____ DOB:_____ Age:_____

Parent/guardian Name: _____DOB:_____

Address: _____

City/ State: _____Zip Code: _____

Home Phone: _____ May we leave a message? Yes No
Cell Phone: _____ May we leave a message? Yes No

Email Address _____May we email you? Yes No

Insurance Provider: _____ Name of Plan: _____

Member ID: _____ Insurance Phone #: _____

Name of Insured: _____ DOB of insured: _____

Name of Primary Care Physician or Pediatrician: _____

Phone Number: _____

Name of emergency contact: _____ Phone #: _____

Referral Source: _____

Has your child ever received any type of mental health services (counseling, hospitalization, psychiatric services, etc.)? Yes No

Explain:

Are you or any family members in therapy now? Yes No

Previously? If so, when, with whom, and for what reasons?

Family Information

Siblings (including step-siblings and half-siblings):
Include Name, Age, and Gender

1._____
2. _____
3. _____
4._____

Others in the home (parents, grandparents, cousins, family friends):
Include Name, Age, and Gender

1._____
2._____
3. _____
4. _____

Have any family members had problems with drugs and/or alcohol? Have they received treatment? Are they currently using?

Are you or any family members taking prescribed medications? What are they and what are they being taken for?

Are you, or is anyone in your family experiencing thoughts of harming oneself or someone else?

Have you or anyone in your family experienced instances of physical violence now or in the past?

Have you had problems with natural disasters (i.e.; flood, hurricane) or another traumatic event?

Do you have any special needs regarding therapy, such as a physical disability?

In general, what is your reason for seeking counseling at this time?