

Marilyn Yearian, LPCC

Child/Adolescent Information, History, and Consent

Referred by: _____

Client's Name: _____ Today's Date: _____

Address: _____

Age: ___ Birthdate: _____ Home Phone: _____ Cell Phone: _____

School: _____ Grade: ___ Grades: _____

Emergency Contact: _____ Phone: _____

Phone voice messages Yes No; Text messages Yes No _____

Insurance Information

Insured's ID Number: _____

Insured's Policy, Group, or FECA Number: _____

Insured's Name: _____ Insured's Birthdate: _____

Insured's Address: ___ Same as above or _____

Employer's Name: _____

Insurance Plan Name or Program Name: _____

Is there another health benefit plan? ___ No ___ Yes

I authorize the release of any medical or other information necessary to process this claim with my insurance company.

___ Yes ___ No Signature: _____

I authorize my insurance carrier to directly pay my practitioner.

___ Yes ___ No Signature: _____

Consent

I have the authority to make medical and legal decisions for my child.

I agree to have my child participate in therapy with Marilyn Yearian, LPCC.

Marilyn Yearian, LPCC

Child/Adolescent Information, History, and Consent

Mother Father Guardian Date

For divorced or separated parents, custody arrangement:

Mother's Name: _____ Birthdate: _____

Address: __ Same as above or _____

Phone: _____ Employer: _____

Father's Name: _____ Birthdate: _____

Address: __ Same as above or _____

Phone: _____ Employer: _____

Parents' Marital Status: Mar. Div. Sgl. Sep. Years ____ Number of previous marriages: Mom: ____
Dad: ____

Number of children: Mom & Dad: ____ Mom: ____ Dad: ____

Children and others living in household:

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Previous Psychotherapy: Yes No With whom? _____

Hospitalizations: _____

Physician's Name: _____ Phone: _____

Currently under medical care? Yes No _____

Current medications: None _____

Marilyn Yearian, LPCC

Child/Adolescent Information, History, and Consent

Prenatal, early childhood: WNL _____

Major accidents, illnesses, injuries: None _____

Trauma: None _____

Rape/Molest: None _____

Headaches Trouble Concentrating Heart palp/Panic Tension & Anxiety Follows
Directions

Depressed Lack of joy Trouble sleeping Frequent nightmares Challenges at
home

Irritability Angry Outbursts Poor self image Fearful or shy School
challenges

Paranoid ideas Tired/Low energy Binging/Purging OCD Sxs Appetite
changes

Alcohol use: None Social _____ Binge _____

Drug use: None Present _____ Past _____

Mom: Alcohol: None Social _____ Drugs: _____

Dad: Alcohol: None Social _____ Drugs: _____

Significant family mental health and substance abuse history: _____

Have you ever attempted suicide? Yes No _____

Are you currently experiencing suicidal thoughts? Yes No _____

Past or present thoughts or attempts to harm others? Yes No _____

Present or past legal problems? Yes No _____

When you are under stress or are unhappy, what do you do to feel better:

Who do you turn to for support? _____

Marilyn Yearian, LPCC

Child/Adolescent Information, History, and Consent

What are your strengths and interests? _____

Faith: Catholic Christian JW Mormon Jewish _____ Attends: Regularly Sometimes Non-attender

Why are you coming to counseling? _____

Who wants you to have counseling? Self Mom Dad Other _____

Anything else that comes to mind that I should know: _____

Thanks for filling out this questionnaire!

Marilyn Yearian, LPCC

Phone: (408) 713-0574 Email: yeariancounselingservices@gmail.com