Counseling For Growth, L.L.C.
Client Intake and Information Form

Please fill out this form and circle the responses.

Name: _____ **Date:** _____

Age: _____ **Gender:** _____ **Ethnicity:** Hispanic/Latino *or* Non-Hispanic/Latino

Date of Birth: _____

Race: African American Caucasian Native American Asian American/Asian
Other (please specify) _____

Address: _____
_____

Can Counseling for Growth, L.L.C. send mail to you at the address listed above?
(Please circle one) Yes or No

Phone Numbers- *Home*:_____ *Work*: _____ *Cell*: _____

Which numbers may we contact you at? (Circle one or more) *Home* or *work* or *Cell*

Whom should we contact in case of an emergency? Name: _____
Number: _____ Relationship: _____

Insurance: Do you have medical/healthcare insurance? Yes or No
If yes, what insurance company? _____

Can a representative from Counseling for Growth, L.L.C. contact and/or send diagnostic and therapeutic information/coordinate with your Primary Care Physician or your Child's Pediatrician? Yes or No

If yes, who is your PCP or your child's Pediatrician?
Name: _____ Telephone Number: _____

Would you want to use your insurance to pay for the services if I am recognized as an in Network Provider? Yes or No

How were you referred to this office (i.e. phone book, former/present client, insurance listing, etc.)?_____

Please write what you would like to gain from counseling: _____
_____
_____
_____

Client Signature: _____ Date: _____