Psychotherapy & Pastoral Counseling Associates
Client Information Form-Child/Adolescent

Therapist________

Client #________

Demographic information (child):

Date________ Name of Child____

Address____
Street City State Zip Code

Phone _____________ (H) ____________ (C)_____________ (Other)

Gender ___ Birth date ________ Age ___ Birthplace_____________ Ethnicity________

School __________________________ Grade ____ Contact ___________________

Religious/Spiritual
Preference________________Church/Synagogue/Preference______________

Emergency Contact, relationship __________________________ Phone #_________

***Demographic Information: (*Parent/ Guardian)**

Name ____

Address____
Street City State Zip Code

Home Phone ____________ Work Phone__________ Other Phone____________

Gender ______ Birthdate_________ Age______ Birthplace________________

Employer___________________________ Occupation _______________________

Religious Preference _________________ Church/Synagogue/Other______________

Referral Information:

Who referred your child/you to PPCA?

Name:____

Reasons seeking therapy

1) Please describe the reasons you are seeking assistance at the Pastoral Counseling Center at this time ____

____

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2) Please check with items below that concern you about your child/adolescent:

___Anxiety	___Anger	___Religious concerns
___Bereavement	___Self esteem issues	___Loss of faith in God
___Depression	___Fear	___ Loss of faith in self
___Nervousness	___Self doubt	___Loss of faith with others
___Loneliness	___Guilt	___Loss of hope
___Vocational	___Suicidal feelings	___Loss of meaning
___Sexual Abuse	___Relationship with parents	___Loss of self respect
___Sexual concerns	___Relationship with children	___Loss of Love
___Marriage/relationship	___Confusion	___ Personal Growth

Parent or Guardian Signature (1) ______________________________ Date __________

Parent or Guardian Signature (2) ______________________________ Date __________

Child/Adolescent Signature ______________________________ Date __________

Insurance Company Information

Primary Insurance Name (required) ____

ID #___________________________ Group #___________________________

Address: _________________________________ Phone: ______________________

Secondary Insurance Name (required) ____

ID #___________________________ Group #___________________________

Address: _________________________________ Phone: ______________________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED: ______________________ **DATE:** ____________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described.

SIGNED: ______________________ **DATE:** ____________