Child Registration Form

Name: _____ Today's Date: _____

SS #: _____ Birth Date: _____Age:_____

Home Address: _____ _____ _____
Address City Zip code

School Attending: _____ Grade level: _____

Progress/Problems in School: _____

Please list all phone numbers where we may contact you and which is preferred:

Home: _____ Work: _____ Cell: _____

Parents/Caretaker: Mom_____ Dad_____

Step dad: _____ Step Mom: _____

Other (s) _____ _____

Email (for appointment reminders): _____

Emergency Contact: In case of an emergency whom should we contact?

_____ _____ _____
Name Contact Number Relationship

Who referred you? _____ May we thank the person for your referral? Yes___ No___

If not referred, how did you receive our name? _____

Primary Insurance

Subscriber's Name _____Relationship to Patient: _____ Authorization#_____

Subscribers Date of Birth: _____Subscriber's SSN: _____ Employer: _____

Insurance Plan Name: _____Policy #:_____Group#:_____

Please turn over

Authorization to Pay Benefits & Release Information: I authorize payment of benefits to David Sanchez, LPC, LCAS, for services provided and I authorize David Sanchez, LPC, LCAS to release to my insurance company any medical information necessary to process this claim and/or to obtain authorization for treatment. Signed: _____ Date: _____

Release of Information to Primary Care Physician: Many insurance companies encourage coordination of treatment between the Licensed Professional Counselor and the Primary Care Physician. Please indicate below if you are willing to allow such communication.

- ☐ I do not authorize David Sanchez, L.P.C., L.C.A.S. to release information to my **Primary Care Physician.**

- ☐ I hereby **authorize** David Sanchez, LPC, LCAS, to release confidential information, including intake summary, treatment goals, and treatment recommendations to my Primary Care Physician in order to aid in treatment planning and coordination. This release is valid for one year unless otherwise stated. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. Further understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

Signed: _____ PCP Name: _____ Date: _____

Current Psychiatric/Psychological Treatment: Name of treating Psychiatrist or Psychologist, if any: _____

_____

Describe any type of counseling or psychiatric treatment you have received in the past: _____

_____

Medical:

Name of Physician/PCP:_____PCP Group/Practice Name:_____

Physician Address:_____ Phone:_____

Name of any other current physicians treating you: _____

Describe any current health problems that you are being treated for:

_____ _____

_____ _____

_____ _____

Current Medications: including over-the counter medications, vitamins, minerals & supplements.

Name	**Dosage**	**Start Date**	**Side effects**

Please describe (from your view) the reason for today's visit: _____

_____

_____

List people your child lives with and their relationship to them:_____

_____

Please mark any of the following problems that you feel may be troubling <u>your child</u>.

Emotional/Cognitive

____Feeling nervous, anxious, afraid
____Feeling down, depressed
____Feeling guilty, ashamed
____Feeling hopeless, helpless
____Difficulty expressing feelings
____Difficulty making decisions
____Difficulty concentrating
____Dealing w/a traumatic event
____Racing, recurring thoughts
____Confusing/disturbing thoughts
____Thoughts of suicide
____Feeling alone, unlovable
____Feeling out of control
____Adjustment to new situation
____Shyness/lack of assertiveness
____Dealing with grief/loss

Physical

____ Chronic/terminal illness/pain
____ Panic Attacks
____ Headaches
____ Nightmares
____ Sleep problems/general fatigue
____ Poor appetite
____ Rapid heart beat
____ Weight gain/loss
____ Tightness in Chest
____ Dizziness
____ Nausea or vomiting
____ Health problems
____ Preoccupied w/food, diet, exercise
____ Dissatisfied with body/appearance

Relationships

____Family concerns
____Relationship issues
____Feeling rejected by others
____Friendship issues
____Other

School

____Procrastination
___ School absences
____Underachievement
____Time Management
____Balancing responsibilities
____other

Behaviors

____Attempting suicide
____Binge drinking
____Using Drugs
____Withdrawing socially
____ Acting out sexually
____Self injury (Cutting, burning, scratching)
____Overeating
____Eating less
____Impulsivity
____Recklessness
____Anger problems/irritability

Please check any past, present, or impending problems with your <u>child's</u> immediate family:

□ deaths
□ divorce
□ frequent relocations
□ attempted/completed suicide
□ financial crisis/unemployment
□ debilitating injuries/disabilities
□ serious illness
□ psychiatric disorder
□ legal problems

What are your main goals for therapy?

1. _____
2. _____
3. _____

Thank you for your time, effort and patience with this necessary paperwork.
Your therapist will be will be with you shortly