Red Cliff
COUNSELING & WELLNESS

Red Cliff Counseling and Wellness – Parent Intake

Parent's Name: _____Child's Name: _____

Address: _____ City/State: _____ Zip: _____

Is your child residing at this same address? Yes / No Do you have legal custody? Yes / No

Best Number(s) to reach you at: _____
May I leave a voicemail or text message for you at this number? Yes / No

Email Address: _____
May I leave a message for you at this email? Yes / No

Child's Date of Birth: _____Age:_____ Gender: _____

Ethnicity: _____ Religious Preference: _____

Your Marital Status: _____ How long? _____

Please list the name, age and relationship of all who are residing with you in your home:

_____

_____

Referral Source: _____
Will you be billing insurance or paying privately: Insurance / Private

Please provide a credit card number which I can bill your copay or private pay fees:

Credit Card Number:_____ Exp Date:_____
If billing insurance, please provide the following:

Insurance Name: _____PolicyNumber:_____

Group #:_____Plan Type: _____

Insurance Customer Service Number: _____

Name of Insured: _____ Insured's Employer: _____

Insured's Address: Insured's DOB:

Where do you work or attend school? _____

How many hours per week are you working and/or in school? _____

Where does your child attend school? _____**Grade level:** _____

How many days a week does he/she make it to school? _____ **Average Grades?** _____

Name of child's Primary Physician: _____ **Last time seen:** _____
***It is highly recommended that you and your child have a current physical and wellness exam.**

Does your child have any medical conditions? _____

Please list any allergies: _____

Perscriptions or Over the Counter Meds	Dose	How Long?	Prescribing Physician:

Any previous surgeries or hospitalizations? _____

Has your child seen a therapist or psychiatrist before: Yes / No What for? _____

Who was he/she seeing and what was the time period? _____

Has your child ever attempted suicide in the past? Yes/ No When: _____

Any history of psychiatric admissions? Yes / No When and Where? _____

Any substance abuse concerns in your family? _____

Has your child ever been physically, emotionally, or sexually abused? Yes / No

If so, could you please describe the type of abuse and when this occurred: _____

_____

_____

Is there any family history of mental illness or substance abuse? _____

_____

What is your primary goal of seeking therapy for your child at this time? _____

_____