

BEAR RIVER HEALTH



Client intake information-Child (17 or younger)

To help me with our first session, please fill out the following information as completely as possible. Today's date: _____

Name (of client): _____

Date of Birth (of client): _____ Age: _____

Name of client's parents (please designate biological or step)

Name of client's siblings with ages (please designate full or half):

Home Address

Home phone: _____ Cell phone: _____

Has child ever talked about or attempted suicide? : _____

Has child been to counseling before? : _____

If yes, list names of counselors child has seen: _____

Family Physician: _____

Name of Practice: _____

Phone #: _____

Is Child taking any prescription medications? _____

If yes, what drugs?

For what purpose is he/she taking these drugs?

Health Insurance? : _____ If yes, Name of Company: _____

Group #: _____ Contract number? : _____

Primary parent's social security number: _____

Referral source? _____

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