Holly T Mitchell – TX LPC - Counseling Practice

Patient Information – CHILD

Patient's Name: Date of Birth: Age:

Referred By: Social Security Number:

Address: City/State:

Zip: Email Address:

Cell: Primary Care Physician:

Parent/Guardian Information

Father: Mother:

Alternate Phone: Email Address:

Emergency Contact: (Name) (#)

Parents: [ ] Married [ ] Divorced [ ] Remarried [ ] Never Married Date(s): _____

Others in the home:

NAME	AGE	RELATIONSHIP TO PATIENT

If parents of child are not currently together, describe your child's current custody status:

_____

Alternate Parent's Name and Phone #: _____

Insurance Information

Insurance Provider:

Member ID: Group ID:

Name of primary carrier: DOB of primary carrier:

List All Current Medications

MEDICATION	DOSAGE	DATE STARTED	PRESCRIBING DOCTOR

Has patient previously been in counseling: [ ] Yes [ ] No
Name of previous therapist: _____
Date/Length of treatment: _____

List any psychiatric or inpatient treatment and dates: _____
_____

Describe presenting problem: _____

_____

_____

_____

_____

_____

_____

Date of onset: _____

Are you currently having thoughts of hurting yourself or others: [ ] Yes [ ] No

If yes, please describe: _____

_____

_____ _____ _____
Signature of Person Completing Form Relationship to Patient Date