Annette Hodgson, LCSW
Adult, Child, Adolescent, Family and Couples Counselor
East Cobb Center for Therapy
3855 Shallowford Road, Suite 420
Marietta, Georgia 30062
770-592-0566, 770-993-8004 (fax)

Initial Client Evaluation for Children and Teenagers

Child's Name:____

Parent Name(s):____

Address:____

Birth Date: _________________________
Insurance carrier Birth Date_____________
Parents Name:__________________________

Does the insurance carrier live at the same address as the child? If not, what is the address and phone number of the insurance carrier?
____
Please give the telephone number in that a voice mail message may be left. Please remember that cellular phones are not necessarily confidential due to technology.

Home:__________________Cellular:___________Work:__________________

Email to send communication____

Would you be comfortable texting information about scheduling appointments?________

Siblings:
Name_______________________________ Age_________ Live with child: ❒Yes ❒No
Name_______________________________ Age_________ Live with child: ❒Yes ❒No
Name_______________________________ Age_________ Live with child: ❒Yes ❒No
Name_______________________________ Age_________ Live with child: ❒Yes ❒No

Parents: Mother's Current Age_________

Father's Current Age__________

Are there step parents or other relatives raising child?

Confidential Medical Information:

Does your child have any allergies (medication/food/environmental)? ❒No ❒Yes ______________________

Medical problems:____

Prescribed medications:____

Over-the counter medications:____

In case of a medical or other emergency, please tell us who you would like us to call:

Name:_________________________ Relationship:__________________ Phone:__________________

Counseling Information:
Reason for coming to counseling/desired services:_________________________________
____

Have you been in treatment or counseling before? ❒Yes ❒No If yes, please give the following info:

Problem:__________________________Month/Year________________ Center:_______________

Were you satisfied with the results: ❒Yes ❒No

Problem:__________________________Month/Year________________ Center:_______________

Were you satisfied with the results: ❒Yes ❒No

Has your child expressed suicidal thoughts? ❒Yes ❒No
Is there a history of anxiety and or depression or other psychological problems in your family? ❒Yes ❒No

Has your child been a victim of sexual, physical or verbal abuse? ❒Yes ❒No

Parent signature (must be legal guardian):
____ Date:______________
Clinician: _______________________________________ Date:_____________
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