PATHWAYS
Mental Health Services

DEMOGRAPHIC FORM

(CHILD & ADOLESCENT)

I. Personal Information

Child's Name: _____

Date of Birth: _____ Age: _____ SS # - -

Address: _____

City: _____ Zip Code: _____

Education:

Currently in Grade? _____

Has IEP? ☐ Yes ☐ No 504? ☐ Yes ☐ No

Parent(s) Name(s):

Mother's Name: _____

Father's Name: _____

Telephone Number: Home: ( ) _____ **Cell:** ( ) _____

Mom's Occupation: _____

Father's Occupation: _____

Email: _____

Referral Source: _____

Insurance Information:

Insurance Name: _____

Group Number: _____ Subscriber # _____

Primary Insured Person: _____ DOB of Primary Insured: _____

SS# of Primary Insured/Sponsor: _____

Insurance Mental Health Contact No: _____ Effective Date: _____

II. Counseling/Therapy

Has your child been in counseling/therapy before? Yes: ___ No: _____

If yes, with whom? _____

Name of previous counselor/therapist

Address: _____

Telephone Number: _____

Outcome of counseling/therapy with previous provider/s:

_____

_____

_____

_____

III. Medical History

Pediatrician/Primary Care Physician: _____
Address: _____
Telephone Number: _____

Current medications (prescribed and over-the-counter)

_____
_____
_____

Any mental health hospitalization? _____ No: ____
Yes: Name of Hospital: _____

Alcohol and Drugs (Past & Present):

_____
_____
_____

Reason(s) for seeking counseling/therapy:

_____
_____
_____
_____
_____
_____
_____
_____
_____

IV. Financial Policy

Payment is due at the beginning of each session. A *48-hour notice is required* for cancellations. Except for unforeseen circumstances, such as emergencies, otherwise you will be charged full fee for appointment missed. ***If your insurance denied our claim you are responsible for the full amount of the counseling fees.***

Child Signature: _____ Date: _____
(13 years old and above only)

Parent Signature: _____ Date: _____
(Parent or Guardian only)