ChildSafe
Start the healing

IDENTIFYING INFORMATION

Please answer each question carefully and ask for clarification if you do not understand. The information on the questionaire will be helpful in planning services for you, is confidential and will not be released without your permission.

Client Name: **Age:** **Sex:** **Date of Birth:**

Address:

City: **State:** **Zip Code:**

Home Phone: **Okay to leave message?:** ☐

Cell Phone: **Okay to leave message?:** ☐

Work Phone: **Okay to leave message?:** ☐

Martial Status: **Race:** **Religion:** **Disabled?:** ☐

Occupation: **Place of Employment:**

Monthly Family Income:

Email Address :

O.K. to contact you via email?: ☐

Would you like to receive ChildSafe's e-newsletter and other announcements?: ☐

Other Family Members:

Name	Age	Date of Birth	Relationship
1)_____	--_____	_____	----_____
2)_____	--_____	_____	----_____
3)_____	--_____	_____	----_____
4)_____	--_____	_____	----_____
5)_____	--_____	_____	----_____

Reason for Seeking Help_____
_____
_____

Who Referred you to ChildSafe?_____

Name of client's physician_____ **Phone Number**_____

List any medications client is currently taking and the reason why_____
_____

Have you had previous psychological, psychiatric counseling?_____

Name of therapsit and reason for seeking help_____
_____

Emergency Contact Person: _____ **Phone Number:** _____

Do you have health insurance that covers mental health out patient counseling? _____
If so, ChildSafe will need a copy of your insurance card. You are responsible for any pre-approval if your insurance policy requires that process before beginning therapy.

Name of Insurance Company_____
Name of Policy Holder_____ **Date of Birth**_____
Social Security # of policy holder_____

If you qualify for Victim Compensation and/or Core Service funding please be aware that your insurance must be billed prior to ChildSafe billing those resources. Your signature on this form gives ChildSafe permission to bill these resources on your behalf and also gives permission for therapist(s) to submit treatment plans to your insurance company, Victim Compensation and Core Services.

You are responsible for any unpaid balances. Please see attached Financial Statement.

Signature of Responsible Party_____ **Date**_____

Signature of Intake Therapist_____ **Date**_____