

Genesis Counseling Services, Ltd.

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www.genescounselingservices.com

Child/Adolescent Questionnaire

Client Name: _____

Address: _____

City: _____ Zip: _____

Date of Birth: _____ Age: _____

Name of Mother: _____

Name of Father: _____

Names and ages of siblings: _____

Client resides with: _____

Relationship to client: _____

Preferred means of contact:

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Student: Yes No

Name of school: _____

Grade: _____

Does client have a Legal Representative/Guardian?

Does client have a Foster Parent/Caretaker?

Does client have a Payee?

Does client have a Primary Physician? Yes No

If yes, please provide name, clinic & phone: _____

Does client have a Social Worker? Yes No

If yes, please provide name & phone: _____

Has client taken medications in the past 12 months? Yes No

If yes, please list: _____

Has client received mental health treatment in the past 12 months? Yes No

If yes, please describe: _____

Client/Representative Signature / Date

Primary Insurance: _____

(Please present card to office staff)

Cardholder's Name: _____

Date of Birth: _____

Relationship to Client: _____

Address: _____

City: _____ Zip: _____

Phone: _____

Employer: _____

Secondary Insurance: _____

(Please present card to office staff)

Cardholder's Name: _____

Date of Birth: _____

Relationship to Client: _____

Address: _____

City: _____ Zip: _____

Phone: _____

Employer: _____

Yes No If yes, see back

Yes No If yes, see back

Yes No If yes, see back

Office Staff Signature / Date

Legal Representative/Guardian:

Name: _____

Address: _____

Phone Number: _____

Must sign intake paperwork

Foster Parent/ Caretaker:

Name: _____

Address: _____

Phone Number: _____

Will receive reminder phone calls

Payee:

Name: _____

Address: _____

Phone Number: _____

Will receive monthly statements