



LIFELINE COUNSELING CENTER
 4212 State Route 306 STE-306
 Willoughby, OH 44094
 440.942.0100 www.lifelinecounseling.net

CHILD PATIENT INFORMATION

Date _____ Social Security # _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone-Home _____ Cell _____

Gender M F Age _____ Birthdate _____

School _____ Grade _____

Mother _____

Father _____

Siblings & Ages _____

Preferred _____

Email _____

Emergency Contact _____

Relationship _____ Phone _____

INSURANCE

Who is the primary policyholder? Mom Dad

Name _____

Birthdate _____ Social Security # _____

Primary insurance company: _____

ID # _____ Group # _____

Who holds secondary insurance? Mom Dad

Name _____

Birthdate _____ Social Security # _____

Secondary company _____

ID# _____ Group # _____

What is the reason for your appointment?

Who may we thank for referring you? _____

MEDICAL HISTORY

- | | | |
|--|---|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Eating issues | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Sleep issues |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid issues | <input type="checkbox"/> Weight loss |

- Does your child smoke? No Yes
- Does your child drink? No Yes
- Does your child use drugs? No Yes
- Hospitalized? No Yes
- Ever physically abused? No Yes
- Ever sexually abused? No Yes
- Ever emotionally abused? No Yes
- Suicidal thoughts? No Yes
- Suicide attempt(s)? No Yes
- Is your child sexually active? No Yes
- Is your child on an: IEP 504 Plan

HEALTH CARE PROVIDER AND MEDICATIONS

Physician _____

City _____ Specialty _____

Under doctor's care now? No Yes

Reason _____

Medications and dosage you are taking now None

Allergies to medication? None

Insurance Assignment and Release

To the best of my knowledge, my intake information is complete and accurate. I understand that it is my responsibility to inform my provider of any change in my insurance or health. I certify that I have insurance coverage with the company(ies) named above, and assign directly to LifeLine Counseling Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. LifeLine Counseling Center may use my health care/insurance information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment is completed or one year from the last date of service.

X _____ Date _____
 BENEFICIARY/GUARDIAN/GUARANTOR