Intake Date_____ Presenting Diagnosis _____
Office use *Office use*

***CHRISTOPHER H. ANDERSON, LCSW* - CLIENT REGISTRATION INFORMATION (Please Print)**

Please fill out all items below. The items in bold print are required by your insurance company to submit a claim.

Client Information

Client Name _____ **Date of Birth**_____
Address _____ **Social Security #**_____
_____ **Relationship to Insured (Circle One)**
_____ Self Spouse Child Other
Phone (h)_____ **Sex** F _____ M _____
Phone (w) _____ **Marital Status** S___M___D____W____ P ____
Phone (cell)_____ **Student Status** N____ F____P____
Primary Care Physician _____ Employer _____
PCP Address _____ Referred By _____
_____

Insured/Guarantor Information (If the Insured is the Client, fill in only the two boxes below)

Insured's Name _____ **Date of Birth**_____
Address_____ **Social Security #** _____
_____ **Sex** F_____ M_____
_____ **Empoyment Status (Circle One)**
Full Time Part Time Unemployed Retired

Phone (h) _____
Phone (w)_____
Phone (cell)_____

Employer _____ Occupation _____
Insurance Company Name _____ Plan Type _____
Insurance ID# _____ **Group #**_____
Insurance phone # _____ **Employment Status** F ___ P ___ N/A ___

*** If there is other insurance to cover this patient, print information on the back of this form*.

Beneficiary/Guarantor Signature (Initial and Sign)

_____ I request that payment of the authorized insurance, Medicaid, and Medicare benefits be made on my dependents or my behalf to Christopher H. Anderson, LCSW for the services furnished me or my dependents by the provider. I authorize any holder of medical information about my dependents or myself to release to the Centers for Medicare and Medicaid Services and its agents or my insurance company any information needed to determine the benefits payable for related services.

_____I understand that even though Christopher H. Anderson, LCSW or his agent will submit claims to my insurance, I am responsible for the portion of my bill considered to be my insurance co-payment, co-insurance, deductible, or other charges not covered by insurance including non-payment for my failure to comply with insurance guidelines regarding prior authorization of treatment related services. .

_____ **I understand there will be a charge for late cancellation (less than 24 hours) or failure to show for an appointment. This is not covered by insurance.**

X_____ Date _____
Signature of Beneficiary/Guarantor

Name of client _____ Date _____

School		Grade ___	City
Father's name		Occupation	
Mother's name		Occupation	
Form completed by		Relationship to child	

Household (list all who live in home – use back if necessary)

Name	*Relationship to Client*	*Date of Birth*

In case of emergency

Contact name _____ Relationship to client _____

Mobile phone _____ Home phone _____ Work phone _____

Health information (use back if necessary)

List any current health concerns _____

Current prescribed medications	*Purpose*

If your child is currently taking any psychiatric medications, who prescribed them? _____

And in what city or town is their practice located? _____

Previous mental health or substance abuse treatment (including inpatient or outpatient services)

Year of treatment	*Treatment provider*	*Type of treatment*	*Length of treatment*

Please think about what brought you here today.

1. Mark the check box of <u>one or two</u> problems that you believe are the most troublesome for your child.

2. On a scale of 0 to 5, please rate how you believe your child feels today about <u>each problem</u> in the list.

		No problem									Worst I've ever felt
☐	Depression	0	1	2	3	4	5	6	7	8	9	10
☐	Anxiety/Stress	0	1	2	3	4	5	6	7	8	9	10
☐	Grief/Loss	0	1	2	3	4	5	6	7	8	9	10
☐	Self-Esteem Issues	0	1	2	3	4	5	6	7	8	9	10
☐	Relationship Problems	0	1	2	3	4	5	6	7	8	9	10
☐	Substance Abuse/Addiction	0	1	2	3	4	5	6	7	8	9	10
☐	Anger/Aggression	0	1	2	3	4	5	6	7	8	9	10
	Other (write in here)	0	1	2	3	4	5	6	7	8	9	10

_____