



Who referred you to KidsHeart Counseling? \_\_\_\_\_

Reason for referral/ visit? \_\_\_\_\_

Family Physician: \_\_\_\_\_

Medical concerns, including allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Who prescribes? \_\_\_\_\_

School Child Attends: \_\_\_\_\_ Grade: \_\_\_\_\_

Any school related concerns? \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Insurance Information: Policy \_\_\_\_\_

Primary Cardholder \_\_\_\_\_ Cardholder DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy # \_\_\_\_\_ Pre-cert/ Benefits Phone # \_\_\_\_\_

Group# \_\_\_\_\_ Cardholder SS# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name of person completing form \_\_\_\_\_

Relationship to client \_\_\_\_\_ Date: \_\_\_\_\_

\*Please bring with you: Insurance card, any custody paperwork (if applicable), and any school or mental health evaluations/ information that might be helpful to the therapist