



**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 responsible for this account?  Dad  Mom

Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Coverage by another insurance company?

Second insurer \_\_\_\_\_

**Insurance Assignment and Release**

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

**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 taking now  None

Allergies to medication?  None

Prior counseling?  No  Yes

What is the reason for your visit today?  
 \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

To the best of my knowledge, this intake information is complete and accurate. I understand that it is my responsibility to inform my provider of any change in my child's insurance or health.

X \_\_\_\_\_ Date \_\_\_\_\_