

Client Information

Full Name of Person Receiving Therapy:

Date of Birth:

Age:

Gender (optional):

Parent/Guardian Name (if under 18):

Phone Number:

Email Address :

Address:

Reason for Seeking Therapy

“Please describe the main concerns or issues that led you to seek therapy.”:

Current Symptoms

(Checkboxes)

- Anxiety / Excessive Worry
- Depression / Sadness
- Trauma / Past Abuse
- Behavioral Problems
- Anger / Aggression
- School Problems
- Family Conflict
- Relationship Issues
- Grief / Loss
- Substance Use Concerns
- Attention / Hyperactivity Issues
- Other

Have you tried therapy services before?

Checkbox Y/N

What was your experience?

Safety & Risk Screening

1. Have you had thoughts of harming yourself in the past 30 days?
2. Have you had thoughts of harming someone else in the past 30 days?
3. Have you ever attempted suicide?
4. Do you currently have a plan to harm yourself or others?

If yes to any above, please explain:

Insurance & Billing

Insurance Company:

Policy Holder Name:

Member ID:

Group Number:

- I authorize Teaching Family Homes to bill my insurance.
- I understand I am financially responsible for copays, deductibles, or non-covered services.
- I do not have insurance and I am interested in a sliding fee scale.