CORNER CANYON COUNSELING & PSYCHOLOGICAL SERVICES

248 East 13800 South, Suite 4
Draper, UT 84020
Phone: 801.816.1801 Fax: 801.501.0249

CHILD AND ADOLESCENT INTAKE FORM
Date _____

Patient Information

Name _____ Social Security Number _____
Date of Birth _____ Sex _____ Age _____
Street Address _____
City _____ State _____ Zip_____
Home Phone _____ Cell Phone _____
Email Address _____
School _____ Year in School _____
Father's Name _____ Occupation _____
Phone Numbers for Father _____
Mother's Name _____ Occupation _____
Phone Numbers for Mother _____
If there are step-parents please also list them:
Step Father's Name _____ Occupation_____
Phone numbers for Step-Father _____
Step Mother's Name _____ Occupation _____
Phone Numbers for Step Mother _____

Insurance Information
Information on Primary Insurance Company
Insurance Company _____
Policy Holder's Name _____Social Security Number_____
Policy Holder's Address _____
Policy Holder's Date of Birth _____ Insurance ID _____
Policy Holder's Employer _____
Relationship of Patient to Policy Holder _____
Address of Insurance Company _____
Phone Number of Insurance Company _____
We do not bill secondary insurance but will be happy to provide you with necessary information so that you can complete your billing to them.
Email Address where statement should be sent _____
Physical Address where statement could be sent _____
_____

Medical and Counseling Information

Primary Care Physician_____
Psychiatrist_____
Date of Last Physical Examination_____
List health problems your child/adolescent has had in the past

_____
_____
_____

List health problems your child/adolescent is experiencing now

_____
_____

List any prescription medications, herbal remedies, over-the-counter medications, or food supplements that your child/adolescent is currently taking:

Medication	Dosage	Taken for?	Prescribing Physician

Has your child/adolescent experienced any adverse reactions to medications? Please list the medication and the reaction:

Medication	When taken?	Adverse Reaction

List psychological medications your child/adolescent has taken in the past:

Medication	When taken?	Adverse Reaction

If your child/adolescent has received outpatient psychotherapy in the past, please list the names of those who have provided that service.

Psychotherapist	Dates seen	Diagnosis

If your child/adolescent has received inpatient treatment in the past for psychiatric or psychological treatment, list the location and dates of the treatment.

Hospital	Dates of hospitalization	Diagnosis

Please explain why your child/adolescent is seeking professional help at this time:

_____

_____

Please explain any recent event/s that may contribute to present symptoms.

_____

_____

May we remind you by phone or email of upcoming appointments and let you know of openings when you need an appointment? _____
What email may we use for appointment reminders? _____

If you prefer to be called, what number(s) should we use to reach you? _____

May we leave voice mail regarding appointments? _____

May we leave messages regarding your appointments with others who may answer your number?

_____

Signature _____

Reminder e-mails and phone calls are a courtesy. At times, we may be unable to provide this service. Remember that you are ultimately responsible for your scheduled appointments.