CARAMENICO
COUNSELING GROUP, LLC

CLIENT INFORMATION		
Client Name:		
SSN:	D.O.B.:	
Address:		
Telephone Number:	Is it okay to leave a message? ☐ YES ☐ NO	
Cell Number:	Is it okay to send text message? ☐ YES ☐ NO	
Email Address:	Is it okay to send email to you? ☐ YES ☐ NO	
Preferred contact method: ☐ Telephone ☐ Cell and Voicemail ☐ Cell and Text Msg		
If client is under age of 14, please provide the names of parents/guardians		
Parent/Guardian Name:		
Parent/Guardian Name:		
Are both parents/guardians in agreement with client participating in treatment? ☐ YES ☐ NO		
PRIMARY INSURANCE INFORMATION (If applicable)		
Primary Insurance Carrier:		
Insurance ID#:	Group #:	
Insurance Policy Holder:	D.O.B.	
Relationship to Client:		
Insurance Contact Number:		
Co-pay:	Deductible:	Co-Insurance:
SECONDARY INSURANCE INFORMATION (If applicable)		
Secondary Insurance Carrier:		
Insurance ID#:	Group #:	
Insurance Policy Holder:	D.O.B.	
Relationship to Client:		
Insurance Contact Number:		
Co-pay:	Deductible:	Co-Insurance:
BACKGROUND INFORMATION		
Presenting Concern (What brings you to treatment?)		
Are you currently involved in a legal matter, custody dispute or pending lawsuit? ☐ YES ☐ NO		
If yes, please be advised that therapist does not offer legal advise nor does she participate in Court-related matters, such as, but not limited to: divorce, custody matters, worker compensation/disability, and/or criminal matters unless otherwise arranged PRIOR TO the commencement of services. Such involvement requires additional fees that are not covered by insurance or part of the therapeutic fee schedule.		
Primary Care Physician:		
Office Number:		
☐ I authorize CCG to communicate with my PCP	☐ I DO NOT authorize CCG to communicate with my PCP	
Client's Academic Institution:	Grade/Level:	
Client's Employer:	Duration:	
EMERGENCY CONTACT INFORMATION		
Name:		
Relationship:	Contact #:	

MEDICAL HISTORY (ALL CLIENTS)	**PSYCHIATRIC/MENTAL HEALTH HISTORY** (ALL CLIENTS)
Allergies:	Has consumer been hospitalized due to Mental Health concerns in the last 12 months? ☐Yes ☐No
	Reason for hospitalization:
Major Medical Conditions:	Has consumer participate in Outpatient Mental Health Treatment in the last 12 months? ☐Yes ☐No
	Is consumer currently receiving Psychiatric Care? ☐Yes ☐No
Recent Medical Hospitalizations/Surgeries:	Name of Psychiatrist:
	Contact:
	Most recent Mental Health Diagnosis (reason for psychiatric treatment):
Current Medication (including psychotropic meds):	
	Family history of mental illness (please specify)
Any history of head trauma? ☐Yes ☐No	
When and severity of injury:	
☐Client did not provide info at time of Intake	***☐Client did not provide info at time of Intake***
DEVELOPMENT HISTORY (CLIENTS AGE 4-17)	**DRUG & ALCOHOL HISTORY** (CLIENTS AGE 12 and Older)
Did child have any delays in meeting developmental milestones: ☐Yes ☐No	Does consumer use tobacco? ☐ Yes ☐ No Age of first use: _____
If Yes, please identify:	Frequency _____ Duration _____
	Does consumer currently use drugs? ☐Yes ☐No Age of first use: _____
	Frequency _____ Duration _____
Relevant Prenatal History (Labor and Delivery):	Does the consumer drink alcohol? ☐Yes ☐No Age of first use: _____
	Frequency _____ Duration _____
	Has consumer ever participated in D&A treatment? ☐Yes ☐No
Relevant Perinatal History (Gestation and first month):	
	If yes, ☐ Inpatient ☐ Outpatient ☐ IOP
	Has consumer been in D&A in the last 12 months? ☐ Yes ☐ No
Was child exposed to traumatic event or violence between ages of 0 to 17? ☐Yes ☐No	Does consumer feel that his/her current D&A use interferes with his/her daily living? ☐Yes ☐No
If Yes, please explain:	Family history of drug and/or alcohol abuse: ☐ Yes ☐ No
	☐Consumer did not provide info at time of Intake
	COURT INVOLVEMENT (ALL CLIENTS)
	Is Adult Probation/Parole, Child Welfare or Juvenile Probation currently involved with the client? ☐Yes ☐No
CHILD WELLNESS (CLIENTS AGE 4-17)	
Is child up to date with vaccinations: ☐ Yes ☐ No	If Yes, please explain involvement:
Is child up to date with all wellness visits: ☐Yes ☐ No	
Is child up to date with dental visits: ☐Yes ☐ No	
If "No" to any of the above, please explain:	Name of Worker/Officer:
	County:
☐Consumer did not provide info at time of Intake	***☐Consumer did not provide info at time of Intake***
Name of Person Completing this form:	***Relation to Client:***