



# Relational Advantage, Inc.

*The Difference Between Potential and Performance*

## CLIENT REGISTRATION – MINOR / DEPENDENT

Dear Parent / Guardian: Please complete this questionnaire and bring it to the first appointment. We will need a separate form for each person participating in counseling.

### Personal Data

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

SS# \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

*OK to leave messages? Y N*

Cell/Other Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Parent's E-Mail \_\_\_\_\_

Name of School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Please list where child was born and the last two cities/states child has lived in:

Place of Birth \_\_\_\_\_

City/State \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

City/State \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

### Parents' Status and Information

\_\_\_\_ Married to each other since \_\_\_\_\_ and living together

\_\_\_\_ Separated \_\_\_\_ Divorced How long? \_\_\_\_\_

\_\_\_\_ One or both remarried

\_\_\_\_ One or both deceased Which parent? Mother Father When? \_\_\_\_\_

Cause of death \_\_\_\_\_

**Mother/Guardian** Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Phone \_\_\_\_\_

City/ST/Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Job Title \_\_\_\_\_

Spouse (if different from Father) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Father/Guardian** Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Phone \_\_\_\_\_

City/ST/Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Job Title \_\_\_\_\_

Spouse (if different from Mother) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Medical and Psychological History**

Brief comment regarding reason for counseling: \_\_\_\_\_

Current Medical Problems \_\_\_\_\_

Current Medications \_\_\_\_\_

Has client received professional or pastoral counseling within the last five years?    Y    N

With Whom? \_\_\_\_\_ When? \_\_\_\_\_

Has client ever been hospitalized for a psychological condition?    Y    N    Hospital \_\_\_\_\_

Explain \_\_\_\_\_ Dates \_\_\_\_\_

Does client currently have trouble sleeping?    Y    N    Describe \_\_\_\_\_

Appetite/Eating Habits:    Good    Poor    Eats when not hungry    Other \_\_\_\_\_

Any drug or alcohol use you're aware of?    Y    N    How much/how often? \_\_\_\_\_

**Family Constellation**

List siblings according to birth order (include step and half siblings) and indicate if they live in child's home:

<u>Names</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Sex</u>	<u>Birth/Step/Adopted/Foster</u>	<u>In Home</u>
_____	_____	___	___	B / S / A / F	Y / N
_____	_____	___	___	B / S / A / F	Y / N
_____	_____	___	___	B / S / A / F	Y / N
_____	_____	___	___	B / S / A / F	Y / N
_____	_____	___	___	B / S / A / F	Y / N
_____	_____	___	___	B / S / A / F	Y / N

**Blue Cross/Blue Shield Information**

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Claims Address \_\_\_\_\_ Phone \_\_\_\_\_

Employer/Group \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

Authorization/Certification # (if required) \_\_\_\_\_ Effective Dates \_\_\_\_\_ to \_\_\_\_\_

**Parent / Legal Guardian's Permission to Treat a Minor:**

I hereby grant permission for Dr. Todd Linaman to provide counseling services to my child / dependent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Relationship \_\_\_\_\_

We were referred to Dr. Linaman by:    \_\_\_ Insurance Co.    \_\_\_ Employer    \_\_\_ School    \_\_\_ Friend/Family  
\_\_\_ Pastor (Church \_\_\_\_\_)    \_\_\_ Other \_\_\_\_\_