**Rachael Shapiro, LCSW/MPH** - 211 Rachel Carson Way, Ithaca, NY 14850

## A. Client Information

Name: _____

Today's Date: _____ Date of Birth: _____ Referred by: _____

Parent/Guardian: _____

Address: _____

Cell Phone: _____ *OK to text? Y / N* Other Phone: _____

Email: _____ Gender: _____

Emergency Contact Person *(name & phone):* _____

Employer: _____ Occupation: _____

Previous Counseling Experience: _____

## B. Child

School: _____ Teacher: _____ Counselor: _____

## C. Household Composition

| ***Name*** | ***Date of Birth*** | ***Relationship*** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## D. Health Insurance Coverage:

Employer: _____ Physician: _____

Name of Provider: _____ Phone#: _____

Name of Insured: _____ Group: _____

Your Relationship to Insured: _____ Policy ID #: _____

Are you currently taking any medication? *Y / N* If yes, list name and purpose of each medication:

_____