Initial Client Information – Child (< age 18)

Crossroads Counseling, PLLC
3830 Packard Rd, Suite 160, Ann Arbor, MI 48108; Tel/Fax: 734.929.9703

Child's name: _____ Date: _____

Address: _____ _____
(Street) (City) (State) (Zip)

Date of birth: _____/_____/_____ Therapist: _____ Referred by: _____

SS #: _____ Home Phone #: (____)_____ Cell Phone #: (____)_____

Father: _____ SS number: _____ Employer: _____

Address: _____
(If different from above)

Home Phone #: (____)_____ Work phone #: (____)_____ Cell Phone #: (____)_____

Mother: _____ SS number: _____ Employer: _____

Address: _____
(If different from above)

Home Phone #: (____)_____ Work phone #: (____)_____ Cell Phone #: (____)_____

Siblings:	Age:	Date of birth:	Siblings:	Age:	Date of birth:
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

Primary insurance company: _____ Policy holder's: _____ _____

Contract #: _____ Plan: _____ Group: _____ Effective Date: _____ ____

Current mediation(s): _____ Allergies: _____

_____ _____

Previous mental health providers (Name of doctor, facility, or therapist): _____

Emergency contact: _____ Relationship: _____

Address: _____ Phone number: (_____)_____

For Office Use Only

Therapist: _____ Fee: _____ Service(s): _____

Insurance: _____ Y _____ N Dx: _____