

**BRENTWOOD COUNSELING  
ASSOCIATES**

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ SS # \_\_\_\_\_

Home Phone: \_\_\_\_\_ Okay to contact (parent(s)) at home? yes \_\_\_\_\_ no \_\_\_\_\_

Mother: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Okay to contact h/c? \_\_\_\_\_

Work Phone: \_\_\_\_\_ Okay to contact at work? yes \_\_\_\_\_ no \_\_\_\_\_

Father: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Okay to contact h/c? \_\_\_\_\_

Work Phone: \_\_\_\_\_ Okay to contact at work? yes \_\_\_\_\_ no \_\_\_\_\_

Brothers/Sisters: (name/age) \_\_\_\_\_

Previous Counseling Within Past Year? yes \_\_\_\_\_ no \_\_\_\_\_

If yes, did you file with insurance? yes \_\_\_\_\_ no \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policyholder's SS #: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

How did you hear of us? \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

*If insurance is being used, I authorize release of information needed to process insurance claims and that benefits be paid directly to provider. I understand I am responsible for all charges incurred not paid by insurance and that payment is expected at the time of service.*

\_\_\_\_\_  
*Parent/Guardian's Signature*

\_\_\_\_\_  
*Date*