

**Dawn Womack, MSW, LCSW, BACS**  
**Child and Adolescent Counseling, LLC**  
 Email Haley [@dawnwomack.com](mailto:dawnwomack.com) Website [www.dawnwomack.com](http://www.dawnwomack.com)  
 Phone (225) 647-5500 Fax (225) 208-1366

**Please fill out the following information as completely as you can. Anyone can fill out the paperwork but only the client's legal guardian may sign documents.**

Name:	Birthdate:
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Age:	School/Employer:
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Address:
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City, state, zip code:
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Emergency contact name/number:
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Insurance company:	Is this a Medicaid plan? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Policy holder's name:	Date of birth:

Policy holder's address:
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City, state, zip code:
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Do you have a secondary insurance: <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>	<b>If yes, provide the following information:</b>
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Secondary insurance company:	Is this a Medicaid plan? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
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Secondary policy holder's name:	Date of birth:
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Secondary policy holder's address:
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City, state, zip code:
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Who referred you to us?
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Have you had counseling before (including school counselors)? **Yes**  **No**  If yes, please describe:

List previous counselor(s), reasons for and outcome of counseling:

What concerns bring you to counseling?

When were these concerns first noticed?

What would you like to gain from counseling?

Have you been affected by any of the following traumatic experiences:
Separation or Divorce of Parents: <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Emotional or Psychological Abuse: <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Neglect or Abandonment: <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Disasters (flood, hurricane, tornado, house fire, war): <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Life threatening injuries (burns, falls, near drowning): <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Witnessed Domestic Violence: <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Absent Caregiver: <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Mental Illness in Family History (including anxiety/depression): <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Substance Abuse in Family History: <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Physical abuse: <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> If yes, answer question in bold below
Sexual abuse, sexual assault, rape: <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> If yes, answer question in bold below

What are your strengths?
What are your weaknesses?

Your physician:

Are you taking any prescription drugs at this time? Yes  No  If yes, please list medication/purpose:


I understand that Dawn Womack does not participate in court issues: **Yes**  **No**

To receive text or email appointment reminders (or both), please provide your contact information below:

Text:

Email:

Please note: appointment reminders are computer generated. If you do not receive a reminder confirming an appointment you believe to be scheduled, please contact our office to verify that your appointment is on the schedule. Carefully read the time and date on the reminder(s) you receive and resolve any conflicts prior to the scheduled appointment time. We use the computer schedule to enforce the 24 Hour Cancellation Policy and suggest signing up for appointment reminders and checking them carefully when you receive or don't receive an expected appointment reminder.