

Dawn Womack, MSW, LCSW, BACS
Child and Adolescent Counseling, LLC
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 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.

Client's name:	Birthdate:
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Age:	Grade:	School:
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Address:

City, state, zip code:

Guardian's cell phone:	Home phone:
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Guardian's email address:

Are you the client's legal guardian: Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, please answer the following two questions:
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If not the client's legal guardian, what is your name and relationship to the client:

If not the client's legal guardian, what is the name and contact number for the client's legal guardian:

Client's insurance company:	Is this a Medicaid plan? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Policy holder's name:	Date of birth:
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Policy holder's address:

City, state, zip code:

Does the client have a secondary insurance: Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, provide the following information:
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Client's secondary insurance company:	Is this a Medicaid plan? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Secondary policy holder's name:	Date of birth:
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Has your child been affected by any of the following traumatic experiences:
Separation or Divorce of Parents: Yes <input type="checkbox"/> No <input type="checkbox"/>
Emotional or Psychological Abuse: Yes <input type="checkbox"/> No <input type="checkbox"/>
Neglect or Abandonment: Yes <input type="checkbox"/> No <input type="checkbox"/>
Disasters (flood, hurricane, tornado, house fire, war): Yes <input type="checkbox"/> No <input type="checkbox"/>
Life threatening injuries (burns, falls, near drowning): Yes <input type="checkbox"/> No <input type="checkbox"/>
Witnessed Domestic Violence: Yes <input type="checkbox"/> No <input type="checkbox"/>
Absent Caregiver: Yes <input type="checkbox"/> No <input type="checkbox"/>
Mental Illness in Family History (including anxiety/depression): Yes <input type="checkbox"/> No <input type="checkbox"/>
Substance Abuse in Family History: Yes <input type="checkbox"/> No <input type="checkbox"/>
Physical abuse: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, answer question in bold below
Sexual abuse, sexual assault, rape: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, answer question in bold below

<p>Was the abuse reported to the Department of Child & Family Services or the police? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If physical or sexual abuse has not been reported to the appropriate agency, please do so before attending an appointment, regardless of the length of time since the abuse occurred, or your appointment will not be held.</p>
Brief description of any abuse that has occurred with the client:

What are the client's strengths?

What are the client's weaknesses?

Describe any developmental concerns in the client's history:

Client's physician:

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Is the client 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

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

Text:	Email:
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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 them and contact our office if you don't receive an expected appointment reminder.