D'Amico & Associates in Counseling

Client Intake for Court-Ordered Services

Parent Education/Coaching – Reunification – Mediation – All Supervised Visitation

Date: _____/_____/_____

Client Name:_____ DOB:_____/_____/_____

Client Name:_____ DOB:_____/_____/_____

Client Name:_____ DOB:_____/_____/_____

Parent/Guardian Name:_____ DOB:_____/_____/_____

Parent/Guardian Name:_____ DOB:_____/_____/_____

Street Address (include apt/unit # if applicable):_____

City:_____ State:_____ Zip Code:_____

Cell Phone: (____)_____-_____ Work Phone: (_____)_____-_____

Home Phone (if available): (____)_____-_____

Email address:_____

Name of Party Responsible for Payment:_____

Referral Source:_____

Current Medication: _____

_____

Requested Service: _____

_____

Attorney Name:_____

Phone: (____)_____-_____ Fax: (____)_____-_____

Address:_____

Please be advised that participation in court-ordered services will reduce the limits of confidentiality observed between this therapist and the court system. Medical privacy protection under HIPAA is guaranteed. Session compliance and recommendations may be required from the GAL or children's attorney.

_____ (Initial understanding)