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)