

Youth Client Information Form (Ages 0-17)

Name of Youth: _____ Date of Birth: _____ SSN#: _____

How does your child identify (Male, Female, Other – Describe): _____

Address (Street, City, State, Zip): _____

Youth's School: _____

Current Grade: _____

Guardian Information

Name: _____ Relation: _____ Date of Birth: _____

Home phone: _____ Work phone: _____ Cell Phone: _____

Is it OK to contact you on these #'s? No Yes If Yes, which one(s)? _____

Is it OK to email you?: No Yes If Yes, E-mail address: _____

Birthplace: _____ Marital status: _____

of times married: _____ # years in current marriage: _____

Occupation: _____

Employer: _____

Education: _____

Additional Guardian Information

Name: _____ Relation: _____ Date of Birth: _____

Home phone: _____ Work phone: _____ Cell Phone: _____

Is it OK to contact on these #'s? No Yes If Yes, which one(s)? _____

Is it OK to email?: No Yes If Yes, E-mail address: _____

Birthplace: _____ Marital status: _____

Occupation: _____

Employer: _____

Education: _____

Who referred you: _____

Family doctor: _____

List any of youth's health problems: _____

Please list any of youth's medications/dosages: _____

Has your child been to therapy before?: _____ No Yes

If yes, when (List all Dates)?: _____

Who did he/she see?: _____

For what issues?: _____

Did it help (explain)?: _____

Please briefly describe Current reason(s) for seeking therapy: _____

Emergency Contact

Name: _____ Relation: _____ Phone Number: _____

Address: _____

Please **Check** any that may be affecting your child, to the best of your knowledge:

ADDICTIONS	DIVORCE	DEFIANCE	SELF-CONTROL	VIOLENT
AGORAPHOBIA	DRUG USE/ABUSE	PEER PRESSURE	SELF-ESTEEM	WORK
ALCOHOL USE	EDUCATION	INSOMNIA	SEXUALITY	OTHER:
AMBIVALENCE	ENERGY (HIGH/LOW)	LONELINESS	SEXUAL ABUSE	
ANGER	EXTREME FATIGUE	MAKING DECISIONS	SHYNESS	
APPETITE	FEARS / ANXIETY	NERVOUSNESS	SLEEP	
BULLYING	FRIENDS	NO INTERESTS	SOCIAL SKILLS	
COMPULSIONS	GENDER IDENTITY	WEIGHT	STOMACH TROUBLE	
CONCENTRATION	HEADACHES	PAINFUL THOUGHTS	STRESS	
CONFIDENCE	HEALTH PROBLEMS	PANIC ATTACKS	SUICIDAL THOUGHTS	
CONFLICT	CHILD ABUSE	PHOBIAS	TEMPER	
CUTTING/SELF-HARM	OPPOSITIONAL	RELAXATION	TIREDDNESS	
DEPRESSION	HOMICIDAL	SADNESS	LOSS OF PARENT	

Please be aware that full payment is expected at the time of your visit. I generally operate on time so please be prompt for your appointment as it will end at the original scheduled time, unless discussed.

Since your appointment time is reserved **exclusively for you**, the cancellation policy is as follows:
Appointments must be canceled 24 hours in advance. Appointments which are not given a 24 hour notice and/or missed appointments without cancellation will be subject to the full fee, as if the appointment was kept. Thank you for your cooperation.

 Printed Name of Legal Guardian
 Page 2 of 2

 Signature of Legal Guardian

 Date