John Cutrone, LMHC, LLC
6810 Lyons Technology Circle, Suite 125, Coconut Creek, FL 33073
Phone: (561) 289-9722 Fax: (561) 544-7149 Website: www.CutroneLMHC.com

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

John Cutrone, LMHC, LLC
6810 Lyons Technology Circle, Suite 125, Coconut Creek, FL 33073
Phone: (561) 289-9722 Fax: (561) 544-7149 Website: www.CutroneLMHC.com

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		TIREDNESS		
	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 Signature of Legal Guardian Date