John Cutrone, LMHC, LLC
2000 Banks Rd., Ste. 217, Margate, FL 33063
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

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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