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# Youth Client Information Form

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

**A. Identification**

Client's name: _____ Nicknames or aliases: _____

Age: _____

Date of birth: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Phone number: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

School: _____

**B. Guardian (s)**:

Name: _____ Relationship:_____

Address: _____ Phone: _____

Email: _____

Primary Guardian: Y____N____ Financially Responsible: Y____N____

Name: _____ Relationship:_____

Address: _____ Phone: _____

Email: _____

Primary Guardian: Y____N____ Financial Responsible: Y____N____

Name: _____ Relationship:_____

Address: _____ Phone: _____

Email: _____

Primary Guardian: Y____N____ Financial Responsible: Y____N____

**C. Referral**: Who gave you my name to call?

Clinic/doctor's name: _____ Phone: _____

Address:_____

If you enter treatment with me for psychological concerns, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

**D. Emergency information**

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: _____ Phone: _____ Relationship:_____

Address:_____

_____ _____ _____

**Signature** **Printed Name** **Date**