New Client Intake Form—Minor

Today's Date ______/______/______

CLIENT INFORMATION

Last Name	First	Middle Initial	Gender	Newsletter Signup ☐ Yes ☐ No
Date of Birth	Age	School		Grade
Previous Schools Attended and Dates		Email Address		

PARENT/GUARDIAN INFORMATION

Last Name	First	Occupation	Employer	
Street Address		City	State	Zip Code
Preferred Contact Number ( )	Home ☐ Cell ☐ Work ☐	Ok to Leave Message ☐ Yes ☐ No	Preferred Method of Communication ☐ Email ☐ Phone ☐ Text	

Marital Status
☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed ☐ Cohabitant

Name of Spouse/Cohabitant

Client Referred By:
☐ Internet Search ☐ Psychology Today ☐ Social Media ☐ Personal Reference:
☐ Professional/Medical Reference: (May we thank this referral?) ☐ Yes ☐ No

Siblings Living in Home (Include Ages)

EMERGENCY CONTACT INFORMATION

Name	Relationship to Client	Phone Number
Client's Physician (Include Address)		Physician's Phone Number

Please describe what brought you and your child to counseling.

Have you or your child been to counseling before? ☐ Yes ☐ No

If yes, please describe when, duration, and what was helpful and/or unhelpful about previous counseling.

Please list ALL medications your child takes, including dosage and reason for taking.