NEW CLIENT FORM (Child/Adolescent)

Designated Client: _____ Date:_____
(For child, parents please fill out information about yourself/selves below)

Name: _____ Partner's Name: _____

Age: _____ Date of Birth: _____ Age: _____ Date of Birth: _____

Mailing Address: _____ Mailing Address(if different)_____

_____

Phone #s: (Home)_____ (Cell) _____ Phone #s: (Home)_____(Cell)

(Work)_____ (Work)_____

E-Mail _____ E-Mail: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Relationship Status: Married___ Committed___ Single___ Divorced___ Separated___ Widowed___

Years in Current Relationship: _____ Dates of Previous Marriage(s)/Committed Relationships: _____

Children	Age	Grade in School
_____	_____	
_____	_____	
_____	_____	

The following information relates to designated client (child):

Age: _____ Date of Birth: _____

Pediatrician:_____

Psychiatrist:_____

Current Medications:

_____

Previous Therapist(s) Seen, When, By Whom:

_____

_____

Emergency Contact: _____ Relationship: _____ Phone: