Client Name: _____ DOB: _____

Parent/Guardian Name: _____

Street Address: _____ City/Town: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

School Name (if applicable): _____ City/Town: _____

State: _____

Name of Primary Doctor/Pediatrician: _____

Psychiatrist: _____

Referred for Mental Health Services By: _____

Insurance Carrier: _____ Card #: _____

Group #: _____

Name of Insured (parent/guardian, if minor): _____

Parent/Guardian DOB.: _____

Employer: _____

Insured (parent/guardian address) if different from above address:

Street Address: _____ City/Town: _____

State: _____ Zip code: _____

Reason for Visit/ Concerns:

Client Strengths/ Interests:

Additional Information (Psychiatric testing, IEP, 504 Plan, Community Supports):

Current Client Diagnosis, if known: _____

Current Medications: _____

Current/ Past Mental Health Treatment:

Past Hospitalizations (if yes, please note dates):

Known Medical Conditions:

Substance Use/ Abuse:

Other Current “At Risk” behaviors (family stressors, cutting, suicidal thoughts, truancy, court involvement):