

**Counseling Specialists, LLP
Youth Client Information Form**

Client _____ (M) ____ (F) ____ Birth Date _____ Age _____
Last Name First Name Middle Initial

Address _____ Phone () _____
Street City/State Zip

Parents E-Mail Address _____

Referral Source _____ Cell () _____
Grade _____ School _____ Religion _____

Employed ____ Yes ____ No Where _____

Primary Physician _____ Psychiatrist _____

Problem for which you are seeking services, _____

Current Medications: _____

Emergency Contact, _____ Phone () _____

Parent/Legal Guardian Information

Marital Status of Parents: Married ____ Single ____ Partnered ____ Divorced ____ Separated ____ Widowed ____
Date Married _____ Divorced Date _____

Father of Client _____ Birth Date _____ Age _____

Address (if different from client) _____ Phone () _____
Leave Mess. ____ Yes ____ No

E-Mail Address _____ Cell Phone () _____ Leave Mess. ____ Yes ____ No
Employer, _____ Phone () _____ Occupation _____
Leave Mess. ____ Yes ____ No

Mother of Client _____ Birth Date _____ Age _____

Address (if different from client) _____ Phone () _____
Leave Mess. ____ Yes ____ No

E-Mail Address _____ Cell Phone () _____ Leave Mess. ____ Yes ____ No
Employer, _____ Phone () _____ Occupation _____
Leave Mess. ____ Yes ____ No

Current Stepparent Information (if applicable)

Stepmother: Name _____ Birth Date _____ Age _____

Address (if different from client) _____ Phone () _____

Stepfather: Name _____ Birth Date _____ Age _____

Address (if different from client) _____ Phone () _____

Other Family Members: (brothers, sisters - if step siblings, indicate with S after name - if child is adopted indicate with A after name)

Name DOB Age Home/Away
