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