

Youth Contact Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____ Legal Sex: Male Female

Current Grade: _____ School: _____ District: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home: _____ Work: _____ Cell: _____

By giving these numbers I give permission for a message to be left.

Parent Name: _____ Youth lives with: _____

Address (if different) _____ Phone/Email (if different): _____

Are there court papers pertaining to custody of the above-mentioned child? Yes or No

If yes, please provide a copy of the court papers by your next appointment.

In case of Emergency Contacts:

Initial Here _____ that I understand that in the event of an emergency/crisis, or if the therapist is unable to clearly determine factors to ensure my own safety or that of someone else in the middle of my Teletherapy Session, my therapist has the right to contact the individuals listed below.

1) Personal Contact: _____

2) Phone Number (s): _____ Relationship: _____

3) Personal Contact: _____

Phone Number (s): _____ Relationship: _____

4) Professional Contact: _____ Phone Number (s): _____

(Doctor or Psychiatrist/if not under a physician's care, write NONE)

Goals for my child: _____ Things I would like to gain from therapy: _____

Strengths my child has are: _____ My strengths as a parent are: _____

Areas of concern: _____ My children's grades are: _____

Additional information about my child: _____

I verify that all the above information is correct and true to the best of my knowledge.

Signature

Date