

YOUTH INFORMATION FORM

Name: _____ Today's Date: _____

Address: _____ City: _____ Zip: _____

Telephone: (home) _____ OK to leave message? Yes ___ No ___

Telephone (cell) _____ OK to leave message? Yes ___ No ___

Do you want to receive communications through text message? Yes ___ No ___

E-mail address if you want to use e-mail: _____

Date of Birth: _____ Age: _____ Sex: _____

School attending: _____ Grade in School: _____

Mother's name (or legal guardian): _____ DOB: _____

Phone #1 _____ Phone #2 _____ Phone #3 _____
home/cell/work Home/cell/work home/cell/work

Father's name (or legal guardian): _____ DOB: _____

Phone #1 _____ Phone #2 _____ Phone #3 _____
home/cell/work Home/cell/work home/cell/work

Others members of household (include name, age, & relationship):

List any medical problems or physical symptoms: _____

List any medications that you are currently taking. _____

Have you ever seen a counselor before? Yes / No

If yes, please rate past experience with counseling (Positive) 1 2 3 4 5 6 7 8 9 10 (Negative)

Please rate the severity of your concerns: (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

What do you want to see happen as a result of coming here? _____

May I contact this person or agency to acknowledge the referral? No _____ Yes _____

Thank you for completing this form.