

Significant Others in the Home:

Name: _____ Relationship to client: _____

Age: _____

Name: _____ Relationship to client: _____

Age: _____

Name: _____ Relationship to client: _____

Age: _____

Name: _____ Relationship to client: _____

Age: _____

Family Information (For Youth Only):

Mother's Name: _____

Address: _____

Phone Number: (Home) _____ (Cell) _____

Father's Name: _____

Address: _____

Phone Number: (Home) _____ (Cell) _____

If we are unable to reach a parent, who can we call to assist us?

Name: _____ Phone: _____

Relationship (grandma, aunt, friend, etc): _____

School Information (For Youth Only)

Name of School: _____

District of School: _____

Contact Person: _____ Phone _____

Grade: _____ Is there a current I.E.P.? yes no

Current Diagnosis:

Source: _____ Date Given: _____

Please List Diagnosis:

Medical Information:

Current Medication (s) and Dosage:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Prescribing Doctor/Psychiatrist: _____

Does the client have any Medical Concerns? Yes No (Explain Below)

Primary Care MD: _____ Phone: _____

Address: _____

Pharmacy: _____ Phone: _____