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Client Information
Minor Child(ren) **Today's Date: _____/_____/_____**

1. Last Name _____First Name_____Date of birth: _____/_____/_____Age: _____

2. Last Name _____First Name_____Date of birth: _____/_____/_____Age: _____

Name(s) of Parent(s)/Legal Guardian(s):_____

Address: _____
Street ***City*** ***State*** ***Zip Code***

Cell Phone: ( ) _____-_____ Home Phone: ( ) _____-_____ Email:_____@_____

**Complete box below only if child's parents live apart from each other:

Parent #2 _____
Home Address: _____City_____ State_____ Zip _____
Cell Phone: ( )_____-_____ Home Phone ( ) _____-_____ Email: _____@_____

If using Employee Assistance Program (EAP) or health insurance , complete appropriate box below:

EAP

Name of Employee: _____ Employee's date of birth: _____/_____/_____
Employer _____ EAP Carrier: _____
Relationship of client to employee: [ ] Self [ ] Spouse [ ] Child
Authorization #: _____ Number of sessions: _____

HEALTH INSURANCE

Insurance Carrier: _____ Name of Insured: _____
Insurance ID #: _____ Insured's date of birth: _____/_____/_____
Insured's SS#: _____- _____-_____ Client's relationship to insured: [] Self [] Child
Is the client covered by any other insurance? [] No, this is primary coverage [] Yes _____

- ***I am responsible for all charges incurred. I attest that all information provided here is true and correct.***

_____

Parent's Signature ***Print Name*** ***Date***

_____

Parent's Signature ***Print Name*** ***Date***