

**YOUTH INFORMATION FORM**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ OK to leave message? Yes \_\_\_ No \_\_\_

Telephone (cell or work) \_\_\_\_\_ OK to leave message? Yes \_\_\_ No \_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

School attending: \_\_\_\_\_ Grade in School: \_\_\_\_\_

Name and number of person I can contact in case of emergency: \_\_\_\_\_

Phone: \_\_\_\_\_

Mother's name (or legal guardian): \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Permission to leave message: Y N

Father's name (or legal guardian): \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Permission to leave message: Y N

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

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? \_\_\_\_\_

Who suggested that you contact me for services? \_\_\_\_\_

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

Thank you for completing this form.