Jennifer L. Harkins, LPC, PLLC

Child/Youth Name: ________________________________Today's Date: _______________

Date of Birth: ____________________ Age: _________ Grade: _______________________

Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Parent's divorced/separated? ___yes ___no If yes, custodial parent: ______________________

Information About Parent(s)

Parent #1 Name: ____________________________________ Date of Birth: _____________

Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Telephone: Cell:________________ Work:_________________ Home:_________________

Employer: ________________________________ Occupation: ________________________

Are you biological parent? ___ yes ___ no Social Security #: __________________________

Parent#2 Name: _________________________________ Date of Birth: ________________

Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Telephone: Cell:________________ Work:_________________ Home:_________________

Employer: ________________________________ Occupation: ________________________

Are you biological parent? ___ yes ___ no Social Security #: __________________________

Youth/Child Background Information

Siblings:	Full/Half:	Age:	Lives with:
______________________________	________________	_______	_________________
______________________________	________________	_______	_________________
______________________________	________________	_______	_________________
______________________________	________________	_______	_________________

Has your youth/child seen a counselor/therapist before? ___ yes ___ no

What are your current concerns?

____

____

____

____

Who is your youth/child's current primary care doctor? ___________________________________

Can s/he be contacted? ___ yes ___ no Phone #: ____________________________________

School: ___________________________________ Social Security #_________________________

CANCELLATION POLICY: If you need to reschedule or cancel an appointment, please call at least 24 hours in advance. If you miss a scheduled appointment, regular fees will be charged to you for that time. Sudden emergencies or illness can be discussed.

FINANCIAL RESPONSIBILITY STATEMENT: I understand that I am responsible for all of the charges incurred for services provided to me and/or my family. I agree to pay my account as services are provided unless other arrangements are made. If there is an outstanding balance on my account, I agree to pay it as soon as I am made aware of the amount owed.

In case of emergency I will call 911 or go to the nearest emergency room.

____ ______________________________

Signature Date