LEGACY

MENTAL HEALTH CENTER

Client Intake Form for Minors

Name: ______________________ Date of Birth: ______________

Gender: __________ Ethnicity: __________ Date of Intake: __________

Name of Parents/Guardian(s): ______________________________

Marital Status of Parents: ______________________________

Custody Arrangements: ______________ ______________

Legal: Physical:

Names and Ages of Siblings: ______________________________

Mother's Street Address: ______________________________

Street, Unit (if applicable), City, State, Zip Code

Phone: __________ __________ __________

Home Cell Work

May We Leave Messages: __________ __________ __________

Home (Y/N) Cell (Y/N) Work (Y/N)

Mother's Employer: ______________________

Father's Street Address: ______________________________

Street, Unit (if applicable), City, State, Zip Code

Phone: ____________ ____________ ____________

Home Cell Work

May We Leave Messages: ____________ ____________ ____________

Home (Y/N) Cell (Y/N) Work (Y/N)

Father's Employer: ______________________

Child's Emergency Contact: ______________________ Phone: ______________

Relationship of Emergency Contact: ______________________

School: ______________________ Grade: ______________

Teacher: ______________________ Phone: ______________

Primary Care Physician: ______________________________

Primary Care Clinic: ______________________________

Address: ______________________ Phone: ______________

Insurance Company (if applicable): ______________________________

Name of Insured: ______________________ Group Number: ______________

ID Number: ______________________ Referred by: ______________