Cameron Pediatric Counseling

## Client Information Form

Today's Date: _____ Date of Birth: _____ Age: _____

Client's Name: _____

Preferred name/Nickname: _____ Gender: _____ Grade: _____

Client Home Address: _____

Client Home Phone Number: (____)_____ Client Cell Number: (____)_____

Client email (only used if necessary for telehealth): _____

School: _____ Location/City: _____

Siblings and ages: _____

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Parent/Guardian: _____ Employer: _____

Best number for contact: (___)_____ e-mail: _____

Parent/Guardian: _____ Employer: _____

Best number for contact: (___)_____ e-mail: _____

Step-parent's name: _____

Step-parent's name: _____

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Significant Allergies/Medical Conditions: _____

Current Medications: _____

Primary Care Physician: _____ Location/City: _____

How did you hear about CPC? ☐ CPC Website ☐ Facebook ☐ School ☐ Primary Care Physician ☐ Friend ☐ Family Member ☐ Counselor/Psychiatrists _____

Has the client received mental health services previously? ☐Yes ☐No

Briefly describe why you are seeking CPC's services at this time: _____

_____

_____

_____

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