Kent Youth and Family Services
Working toward a better future

For Office Use: PH ____ MT ____

CLIENT INFORMATION SHEET

Date: _____

Client (Child) Name: _____ Nickname: _____

Date of Birth (month/day/year) _____Age:_____ Social Sec. No. _____

Address: _____

City / State / Zip _____

Home Phone: _____ Work Phone: _____

Cell Phone : _____

Parent/Caretaker _____ Date of Birth _____

Employer: _____ Work Hours _____

Parent/Caretaker _____ Date of Birth _____

Employer: _____ Work Hours _____

Others living in home (brothers, sisters, stepparents, partners, stepsiblings, etc.)

Name	Date of Birth	Relationship to client	School

Insurance (☐ one type) Medical Coupons _____ No Insurance _____

Private Insurance _____ What insurance plan? _____

What mental health/counseling benefits are covered? _____

_____

Family Gross Income (before taxes) _____/month No. of people in family _____

Name of School _____ Grade _____ Teacher _____

Caseworker Name _____ Phone Number_____

Doctor or Office Name _____ Phone Number_____

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Date of Last Physical Exam _____

Who referred to you Kent Youth & Family Services? _____

_____

Are you required to do counseling? _____ If yes, circle requirement:

Court School Diversion (Conference Committee) Parent

Reason(s) for seeking counseling at this time:

_____

_____

_____

_____

_____

Days and Times Available for Appointment _____

Are there any considerations we should be aware of when matching your family/ child with a therapist?

_____.

Has client or family member had counseling before? If so, where and how long?

_____

Please mark an X if any of the issues below are a concern for this client:

_____ Substance Use _____ Suicidal Thoughts/Gestures _____ Violence Toward Others

I,_____ , am the legal custodial parent/guardian (or youth if over 13 years old)

of the person(s) for which counseling is being requested on this day, _____.

For Office Use:

Assigned to: _____ **Date:** _____

Follow Up Calls _____

_____

_____

_____

_____

_____

_____

_____