Contact Information

Today's Date:_____ **Referral Source**:_____

Adolescent Name:_____ **Age/Date of Birth**:_____

Parent/Legal Guardian(s) Name(s): **Age/Date of Birth**:

_____ _____

_____ _____

Sibling(s) Name(s): **Age/Date of Birth:**

_____ _____

_____ _____

Address of Primary Residence:

_____ **Home Phone**:_____
Please check if OK to leave a message at this number ❑

_____ **Parent Cell Phone**:_____
Please check if OK to leave a message at this number ❑

_____ **Parent Cell Phone**:_____
Please check if OK to leave a message at this number ❑

Email Address(es) *(Please provide for both parents/guardians)*

Name:_____ Email:_____ /Name:_____ Email:_____

If parents are divorced, please note the <u>legal custody arrangements</u>, including if one parent is the sole legal guardian or if joint legal guardianship is in place. Note: When joint legal custody is in place, *both parents must provide consent to treatment*. Documentation of legal custody arrangements may be requested to be provided.

_____

Second Parent/Legal Guardian Address (if different than above):

_____ **Home Phone:**_____
Please check if OK to leave a message at this number❑

_____ **Cell Phone:**_____
Please check if OK to leave a message at this number❑

_____

<u>Emergency Contact Information:</u>

Name(s):_____

Phone Number(s):_____

Relationship to Client(s):_____