**Minor Client Information**

***(Please complete if client is age 18 or younger)***

**Client Name:**  Date:

Age: Date of Birth: Gender (Please Circle): **M** **F**

Address: Home # ( )

City: State: Zip: Cell # ( )

Email Address: (optional):

***Would you like to receive appointment reminders by:*** *Text Email Neither*

School Name:Grade Level:

**Emergency Contact:** Phone # ( )

**Name of Mother:**  DOB:

Address (If different from above:

City: State: Zip: Home # ( )

Employer: Work # ( ) Cell # ( )

**Name of Father:**  DOB:

Address (If different from above:

City: State: Zip: Home # ( )

Employer: Work # ( ) Cell # ( )

Were you referred to this office? **Yes No** If so, by whom?

Primary Physician: Psychiatrist:

***Hope & Healing Counseling, LLC***

*1200 Valley West Drive, Suite 304-04*

*West Des Moines, IA 50266*

*(515) 421-4367*