|  |  |  |  |
| --- | --- | --- | --- |
| NAME [Patient Name] | DOB [DOB] | AGE [age] | DATE [date | time] |

**Client (Child/Adolescent) Information and Emergency Contacts**

|  |  |
| --- | --- |
| Address: [Comments] | Home Phone: [Comments] |
| Address: [Comments] | Work Phone: [Comments] |
| Address: [Comments] | Cell Phone**:** [Comments] |
| If a minor, parent’s/guardian’s name(s): [Comments] |
| Primary Care Physician (PCP): [Comments] | PCP’s Phone: [Comments] |
| PCP’s Address: [Comments] [Comments] | Date of Last Physical: [Comments] |
| Medical Conditions**:** [Comments] | ALLERGIES [Comments] |
| **First Emergency Contact \*** [ ]  **Same as parent/guardian above** |
| Name: [Comments] | Home Phone : [Comments] |
| Relationship: [Comments] | Work Phone: [Comments] |
| Address: [Comments] [Comments] [Comments]  | Cell Phone: [Comments]  |
| **Second Emergency Contact \*** [ ]  **Same as parent/guardian above** |
| Name: [Comments] | Home Phone: [Comments] |
| Relationship: [Comments] | Work Phone: [Comments] |
| Address: [Comments] [Comments] [Comments] | Cell Phone: [Comments]  |
| Agency: | Contact Person: | Telephone: |
| Psychiatrist/RNCS | [Comments] | [Comments] |
| School Counselor | [Comments] | [Comments] |
| DMH | [Comments] | [Comments] |
| DSS | [Comments] | [Comments] |
| Court Contact/Probation Officer | [Comments] | [Comments] |

\*By signing, I give permission for Elizabeth Holmes-Coutracos, LMHC to contact the above emergency contacts in the event of an emergency.

Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Printed Name: [Comments]