Lighthouse Counseling Services, LLC

Personal Data Form - Minor

Date _____ Who referred you to Lighthouse Counseling Services LLC? _____

Individual Counseling

Name (First, MI, Last) _____

DOB _____ Gender (circle one) Male Female SSN _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Other _____

Mother (or Guardian) Name _____

Phone Home _____ Work/Other _____ Cell _____

Father (or Guardian) Name _____

Phone Home _____ Work/Other _____ Cell _____

May we identify ourselves by using the clinic name? (circle one) Yes No

If No, how should we identify ourselves? _____

May we leave a message? (circle one) Yes No

Parent's Marital Status (circle one)

Never Married Married Separated Divorced Widowed Other

Siblings Names and Ages

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Non-Custodial Parent Information

Name _____

Address _____

City _____ State _____ Phone _____

Current School

Name _____ Grade _____

City _____ State _____

Emergency Contact

Name _____ Phone _____

Relationship _____

Treatment

To best coordinate your care, may we contact your primary physician? (circle one)

Yes No

Do you have a psychiatrist? (circle one)

Yes No

To best coordinate your care, may we contact your primary psychiatrist? (circle one)

Yes No

Have you worked or are you working with any other mental health professionals? (circle one)

Yes No

Would you like us to contact this professional regarding your counseling sessions? (circle one)

Yes No

If you answered YES to any of the above, please complete the Lighthouse Counseling Services form titled "***Release of Information Consent Form***".