Jessica Volpentesta, LMHC

Second Nature Counseling
Washington State Licensed Mental Health Counselor #LH60696495
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Client Information - Minor

Date:_____

Name: _____ Age:____ Date of Birth:_____ Gender ID: M F Other_____

Religious/Spiritual Preference:_____ Culture/Ethnicity:_____

School:_____ Grade:____ IEP or 504 Plan? Yes___ No___

Home Address:_____City:_____Zip:_____

Secondary Address (if applicable):_____

Cell Phone:_____ Ok to text? Yes____ No____
Ok to call? Yes____ No____

Email:_____ Ok to email? Yes____ No____

Parent Cell Phone:_____ Ok to text? Yes____ No____
Ok to call? Yes____ No____

Parent Email:_____ Okay to email? Yes____ No____

Best way to contact: Text Call Email

Emergency Contact:_____ Relationship:_____ Phone: _____

Primary Care Physician/Facility:_____

List any medical conditions you have:_____
_____

List any medications/supplements you are currently taking:_____
_____

Briefly describe the main issue(s) which has led you to seek counseling:_____
_____

Have you sought counseling in the past? If so, what for and was it helpful?_____
_____

How did you learn about Jessica Volpentesta, LMHC? Health Care Professional___ Friend___ Psychology Today___ School Counselor___ Other_____

Family Information

Please list each parent/guardian/caretaker involved in your care:

Name:_____Age:____ Relationship:_____Live With? No___ Yes___

Phone:_____Occupation:_____

Name:_____Age:____ Relationship:_____Live With? No___ Yes___

Phone:_____Occupation:_____

Name:_____Age:____ Relationship:_____Live With? No___ Yes___

Phone:_____Occupation:_____

Name:_____Age:____ Relationship:_____Live With? No___ Yes___

Phone:_____Occupation:_____

Other Minors/Siblings who live with you:

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Credit Card Information

Please provide the credit card information you plan to use for payment in the event that you do not use cash or check.

Credit Card #: _____ Expiration Date:_____ Security Code:_____ Zip:_____

_____

Name on the Card: _____

I have a 24 hour cancellation notice. Should you cancel within 24 hours or no show to a scheduled appointment, this card will be charged for the full amount of a regular session.