CLIENT INFORMATION FORM

CLIENT INFORMATION

DATE PRINTED: **LEGAL NAME OF CLIENT:** **DOB:** **AGE:**

PARENT(S)/GUARDIAN(S) NAME (IF APPLICABLE)

CURRENT ADDRESS: **CITY** **STATE** **ZIP**

IF YOU ARE A RETURNING CLIENT

PAST SERVICE PROVIDED **LAST ATTENDANCE DATE:**

CLIENT CONTACT(S) INFORMATION

CONTACT NAME **RELATIONSHIP TO CLIENT**

PHONE **ALTERNATE NUMBER**

EMAIL

CLIENT HISTORY INFORMATION

SCHOOL DISTRICT	NAME OF SCHOOL	GRADE LEVEL

DIAGNOSIS/TREATMENTS HISTORY

PRIMARY PHYSICIAN: **SECONDARY PHYSICIAN:**

DIAGNOSIS FROM PRIMARY PHYSICIAN (IF ANY): **DIAGNOSIS FROM PRIMARY PHYSICIAN (IF ANY):**

OTHER RELEVANT HEALTH INFORMATION:

MEDICATIONS AND SUPPLEMENTS: DOSES AND TIMES TAKEN

MEDICATION: _____ DOSAGE: _____ TIME TAKEN: _____

MEDICATION: _____ DOSAGE: _____ TIME TAKEN: _____

MEDICATION: _____ DOSAGE: _____ TIME TAKEN: _____

MEDICATION: _____ DOSAGE: _____ TIME TAKEN: _____

ANY OTHER MED'S OR TREATMENTS: _____

ALERGIES (FOOD, MEDICATION, ETC.)

TYPES OF SERVICES YOU ARE SEEKING FROM OUR STAFF ?

SOCIAL SKILLS ACADEMY THERAPY ADULT SERVICES SUMMER PROGRAMS

Concerns you might have? / Area's you would like help with?