Laurie Schoenberg MFT
Client Information (minor)

Name: ______________________ ________ _ Date:: _______ _
Date of Birth: ________________ _
Address: _
Source of referral: ____________________________Type(s) of service: _________________ __ _
Home phone: _______________________ Cell phone: ______________________________ _
School: ______________________________Grade: __ Teacher: ______________________ __ _

PARENT(S)/ LEGAL GUARDIAN(S) INFORMATION:

Mother's Name: ______________ ______ ______ __ _
Date of Birth: ________________ _
Address: ___________________ ___City:______ __ Zip Code: ____________ _
Employer: ___________________ ______ _____ _ Occupation: ________________________ _ _
Home phone: ______________ _____ _ Cell phone: _________________________ _

Father's Name: ____________ _________________ _
Date of Birth: ______________ _
Address: _ _ _ _ _ _ _ _ _ _ City: _ _ _ _ _ _ _ _ _ Zip Code: _ _ _ _ _ _
Employer: ___________________________________ Occupation: ________________________ _
Home phone: ______________________________ Cell phone: ____________________________ _

EMERGENCY CONTACT INFORMATION:

Name: ________________________________ Relationship to client: ________________________ _

Address: ____ phone: _________________________ _

OTHERS LIVING IN HOME WITH CLIENT:

Name: ____________________________ _ DOB: ________ Relation to client: ______________ _
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MEDICAL INFORMATION:

Primary Physician: _____ Date of last physical: _____ _
Current Medication(s): _____Purpose(s): _____
Health Issues/ Concerns: _____ _____

Subscriber of Insurance Name:_____

Subscriber's Birthday:

PARENT/ GUARDIAN SIGNATURE: _____ DATE: _____ _

FOR OFFICE USE ONLY:

Completed procedures:_ Entered system Date: _____ _
Confirmed insurance Date: _____ _
Confirmed with client Date: _____ _