

Bethany, Yates & Associates

Personal Counseling & Consulting

Information for Confidential and Professional Use Only

Adolescent

Client's Name: First _____ M.I. _____ Last _____

Address _____

City, State, Zip _____

Home Phone (____) _____ SS Number _____ - _____ - _____

Mobile Phone (____) _____ Work Phone (____) _____

Birthdate _____ Sex Male Female

Responsible Party:

First Name _____ M.I. _____ Last _____

Address _____

City, State, Zip _____

Home Phone (____) _____ Work Phone (____) _____

Mobile Phone (____) _____ e-mail address _____

Who referred you to us? _____

Insurance Company _____ Insurance Co. Customer Service #(____) _____

Insured's name _____ Insured's ID# _____

Insured's address if different from client _____

Insured's birthdate _____

Employer's name _____

May we leave a message for you at work? Yes No

Reason for coming in: _____

Previous therapist: _____ Dates: _____ to _____

Medications currently taking:

1) _____ Dosage/Freq. _____ Start Date _____ Purpose _____

2) _____ Dosage/Freq. _____ Start Date _____ Purpose _____

3) _____ Dosage/Freq. _____ Start Date _____ Purpose _____

Prescribed by _____ Date of last medical evaluation _____ Date of next appt. _____