LEGACY
MENTAL HEALTH CENTER

Client Intake Form for Minors

Name: _____ Date of Birth: _____

Gender: _____ Ethnicity: _____ Date of Intake: _____

Name of Parents/Guardian(s): _____

Marital Status of Parents: _____

Custody Arrangements: _____ _____
Legal: Physical:

Names and Ages of Siblings: _____

Mother's Street Address: _____
Street, Unit (if applicable), City, State, Zip Code

Phone: _____ _____ _____
Home Cell Work

May We Leave Messages: _____ _____ _____
Home (Y/N) Cell (Y/N) Work (Y/N)

Mother's Employer: _____

Father's Street Address: _____

Street, Unit (if applicable), City, State, Zip Code

Phone: _____ _____ _____

Home Cell Work

May We Leave Messages: _____ _____ _____

Home (Y/N) Cell (Y/N) Work (Y/N)

Father's Employer: _____

Child's Emergency Contact: _____ Phone: _____

Relationship of Emergency Contact: _____

School: _____ Grade: _____

Teacher: _____ Phone: _____

Primary Care Physician: _____

Primary Care Clinic: _____

Address: _____ Phone: _____

Insurance Company (if applicable): _____

Name of Insured: _____ Group Number: _____

ID Number: _____ Referred by: _____