Suzette Wasvick Counseling Services, Inc

PO Box 763
280 Main Street, Suite 14
Hill City, SD 57745
Office: 605.390.8791

403 National Street, Ste 1
Rapid City, SD 57702
Office: 605.390.8791

Client Information (Teen) Form

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Nicknames or aliases: _____

Age: _____ Date of birth: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Phone number: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Employer: _____ Work phone:_____

Calls will be discreet, but please indicate any restrictions:_____

B.Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address:_____

If you enter treatment with me for psychological concerns, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ☐ Yes ☐ No

C. Emergency information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: _____ Phone:_____ Relationship:_____

Address:_____

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D. Guardian Information

Mother/Guardian name: _____ Date of birth: _____

Home street address: _____ Apt: _____

City: _____ State: _____ Zip:_____

Phone number: _____ email: _____

Father/Guardian name: _____ Date of birth: _____

Home street address: _____ Apt: _____

City: _____ State: _____ Zip:_____

Phone number: _____ email:_____

Parents are currently: ☐ Married ☐ Divorced ☐ Separated ☐ Remarried

☐ Never married

Client lives with: ☐ Mother ☐ Father ☐ Both ☐ Relative ☐ Guardian

☐ Other:_____

Who has legal custody of client: ☐ Mother ☐ Father ☐ Both ☐ Relative

☐ Foster: _____