Individual Counseling
Marriage & Family
Counseling
Anger Management
Children & Adolescents

Client Information – Child- Confidential

1700 Burleigh Street • Yankton, SD 57078 • 605-260-9284

Please fill out fully to the best of your knowledge.

Client _____
(Child) Last Name First Name Middle Initial

Address: _____
Street/ PO Box City State Zip Code

Gender: _____ Age_____ Date of Birth____/_____/_____

Race: (Please Circle) Asian African American Caucasian Hispanic
Native American Other

Telephone _____Cell/Home/Work

School(if attending)_____ Grade_____

Parent/Guardian_____
Last Name First Name Middle Initial

Address: _____
(If different) Street/ PO Box City State Zip Code

Gender: _____ Age_____ Date of Birth____/_____/_____

Race: (Please Circle) Asian African American Caucasian Hispanic
Native American Other

Telephone _____Cell/Home/Work _____ Cell/Home/Work

Occupation_____ Employer_____

Relationship to client_____ Is the child adopted? YES NO

Brothers, Sisters:

Name	Birthdate	Gender	Name	Birthdate	Gender

Custody arrangements_____

Others living in the home:_____

Major Medical Issues or Surgeries: _____

Medications:_____

_____

Current Physical Symptoms/Ailments_____

_____

Physician:_____ Location:_____

Check all of the following that apply:

____ Stress	_____Grieving a Loss	_____Anxiety/Worry
_____Behavior Problem	_____Parent/Child Relationship	_____Depression
_____Phobia	_____Alcohol or Drug Use	_____Violence
_____Fear	_____Anger	_____Pain
_____ Developmental Disabilities	____Abuse (physical, sexual, emotional)	_____Mood Swings
_____Sleep Changes	_____Health Problems	_____Appetite changes
_____Self Mutilation	_____Difficulty Concentrating	_____Impulsivity
_____Speech/language delay	_____School Issues	_____Hyperactivity

_____Others_____

Who are the child's main supportive individuals?_____

_____

Is spirituality/religion a part of the child's life? Yes No Church:_____

Counseling Goals_____

Referred Here By:_____

Previous Counseling Experience:_____

Counselor:_____

Insurance: If you have your card may we photocopy it for billing purposes?

_____Blue Cross/Blue Shield ____Avera Health Plan _____Sanford Health Plan
_____DakotaCare _____Medicaid _____Other_____

Name on Card:_____

Account Number:_____

Insurance Source (Employer, Self)_____

Insurance Company Address: _____

Insurance Company Phone Number_____

Other information:_____

Signature:_____ Date_____