

PENNY J. FIFE, MFT, CEDS

Confidential Client Information

SECTION 1 – CHILD INFORMATION

First Name: _____	Last Name: _____	Middle Initial: _____
Date of Birth: _____	Email: _____	
Home Address: _____	City: _____	State: _____ Zip: _____
Home Phone: _____	Cell Phone: _____	
School: _____	Grade: _____	
Mother: _____	Cell: _____	Email: _____
Employer: _____		
Father: _____	Cell: _____	Email: _____
Employer: _____	Child lives with: Both Parents Mother Father Other Relatives Other	
Parents Marital Status: Married Separated Divorced Never Married Widowed		
Custody Arrangement (if divorced): Joint Mother Father Other		

SECTION 2 – RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY: *Please fill out the following information about the responsible party.*

First Name: _____	Last Name: _____	Middle Initial: _____
Date of Birth: _____	SS#: _____ - _____ - _____	
Address: _____	City: _____	State: _____ Zip: _____
Home Phone: _____	Work Phone: _____	May we contact you at work? Yes No
Employer: _____		

SECTION 3 – EMERGENCY CONTACT INFORMATION

List the name of a person that we may contact in case of emergency. (Not living with you.)

Name: _____	Relationship: _____	Phone: _____
Address: _____	City: _____	State: _____ Zip: _____

SECTION 4 – GENERAL INFORMATION

List present and previous health problems of your child: _____		
List medications your child is currently taking: _____		
List agencies, persons or other professional resources where your child has obtained service for emotional, social, family or personal concerns: _____		
List your goals concerning counseling at this time: _____		
Siblings:	Name	Age

I hereby declare that I am the legal guardian of the minor child named in section one and I give my consent to Penny J. Fife, MS, MFT to provide treatment to my minor child.

Signature: _____ Printed Name: _____ Date: _____

