Child/Adolescent Client Information

Clouse Counseling, LLC/Wildflowers Counseling
Noelle W. Clouse, LMHC
noellewclouse@wildflowerscounseling.net

Date: ______________________________

Client Name: ______________________________________ DOB: ________________
Gender: ___________________________ Age: _____
Address: ____
____
Cell Phone with Area Code: _______________________
Other Phone with Area Code: _______________________ Type of Phone: ___________
Email: ____

Reason for seeking counseling:

____
____
____
____

Name of Legal Guardian: ____

Address of Legal Guardian:

____
Cell Phone for Legal Guardian: ____
Other Phone for Legal Guardian: _______________________________ Type: __________ Email:
____

Name of Legal Guardian: ____

Address of Legal Guardian:

____
Cell Phone for Legal Guardian: ____
Other Phone for Legal Guardian: _______________________________ Type: __________ Email:
____

Custodial Information (if applicable):

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____
____

Primary Care Physician: ____
Address: ____
Phone: ______________________________ Fax: ______________________________

School: ____
Grade: ____________
IEP or 504 Plan: ________yes. _________no
Other Information:
____
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Form completed by: ____
Relationship to Client: ___________________________