Bethany, Yates & Associates

Personal Counseling & Consulting

Adolescent /Child

Information for Confidential and Professional Use Only

Client's Name: First_____________________ M.I.______ Last_____________________________________

Address____

City, State, Zip____

Home Phone (____)____________________________

Mobile Phone (___)____________________________

Birthdate _________________________________ Sex [ ] Male [ ] Female

Responsible Party:

First Name________________________M.I.______Last____

Address____

City, State, Zip____May we text/email you [ ] Yes [ ] No

Home Phone (____)______________________ Work Phone (____)___________________________

Mobile Phone (____)_____________________ e -mail address__________________________________

Who referred you to us?____

Insurance Company________________________________Insurance Co. Customer Service #(___)__________

Insured's name____ Insured's ID#_______________________

Insured's address if different from client____

Insured's birthdate______________________________

Employer's name____

May we leave a message for you at work? ( ) Yes ( ) No

Reason for coming in:____

Previous therapist:________________________________Dates:________________to____________________

Medications currently taking:

1)_________________Dosage/Freq.____________Start Date_________Purpose_________________________

2)_________________Dosage/Freq.____________Start Date_________Purpose_________________________

3)_________________Dosage/Freq.____________Start Date_________Purpose ________________________

Prescribed by_____________Date of last medical evaluation____________Date of next appt.________________