

EARLY CHILDHOOD *Wellness place*

520 Zang Street Suite 212; Broomfield, CO 80021 (303) 460-3881

Client Information Form

Child Name			Today's Date
Street Address			Date of Birth
City	State	Zip Code	Age
Home Phone	Parent Work Phone	Cell Phone	
Is it OK to call and leave messages at these phone numbers? If not please indicate any restrictions:			
School	Address	Grade Level	
Email Address (Please note: Email correspondence is not considered to be a confidential medium of communication. By giving your email address you are giving consent to correspond through email):			

Parent Identification:

Mother's Name	Date of Birth
Occupation	Phone (if different from above)
Father's Name	Date of Birth
Occupation	Phone (if different from above)
Step-Parent / Caregiver Name & phone if different from above	Relationship to client
Step-Parent / Caregiver Name & phone if different from above	Relationship to client

Referral Information: Please tell me how you got my name, or who referred you to me

Name / Source	Phone
May I have your permission to thank this person for the referral? () Yes () No	

Household Information: Please list other family members or significant people living in your home

Name	DOB / Age	Gender	Relationship to client
Name	DOB / Age	Gender	Relationship to client
Name	DOB / Age	Gender	Relationship to client

Medical History Information: Please give primary client's information

Are you currently taking prescription medications? () Yes () No
 If so, please list names and dosages:

Are you currently taking non-prescription medications? () Yes () No
 If so, please list names and dosages:

Previous Mental Health Treatment History

Date(s)	Provider	Purpose
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Review of Physical Symptoms

YES	NO	Check one for each symptom	YES	NO	Check one for each symptom
		Frequent or severe headaches			Low blood pressure
		Dizziness or fainting spells			Recent loss / gain weight (circle one)
		Eye problems including glaucoma			Diabetes
		Head injury			Epilepsy or seizures
		Thyroid trouble			Jaundice or liver disease
		Asthma or shortness of breath			Kidney disease
		Palpitation or pounding heart			Stroke
		Heart attack / heart trouble			MALES – Prostate trouble
		High blood pressure			FEMALES – Are you currently pregnant or planning a pregnancy in the near future?

Please list any other disease or condition you may not have listed above:

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Printed name: _____

Signature: _____

Date: _____