Gail A. Phillips, LCSW

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Client Intake Form (Minor)

Client Information (Minor)

Full Name ________________________________ Date of Birth ___________ Age _____

Address ____

Phone ____________________ Email ____

Parent Information

Name ______________________________ Name ______________________________

Address ____________________________ Address ____________________________

__________________________________ __________________________________

Phone ______________________________ Phone ______________________________

Email ______________________________ Email ______________________________

Referred by __________________________ Phone ______________________________

May I have your permission to contact your referral source to thank him or her? Yes No

Reason for seeking counseling ____

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I understand that I am responsible for all charges incurred, that I must cancel an appointment at least 24 hours in advance or I will be charged for that appointment, and that I am responsible for missed appointment charges.

______________________________________ ____________________
Signature Date

______________________________________ ____________________
Parent/Guardian Signature Date

______________________________________ ____________________
Parent/Guardian Signature Date