

**Child**

Client Information

Please Print

First Name	M.I.	Last Name	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date
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Street Address	Birthdate
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City	State	Zip	County	Social Security Number
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Home Phone	Other Phone	Who referred you to our agency
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School	Pediatrician
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**Ethnicity:**     African American                       Hispanic                       Asian American or Pacific Islander  
 Native American                       White                       Other                       Multi-racial

Do you have any handicap of which we should be aware?     Yes     No  
If yes, please describe briefly \_\_\_\_\_

Who may we contact in case of an emergency or appointment cancellation? \_\_\_\_\_

**Family Information**

Mother:	Father:		
_____	_____		
Name	Name		
_____	_____		
Address	Address		
_____	_____		
Employer	Occupation	Employer	Occupation
_____	_____	_____	_____

**Parent Authorization for Counseling/Treatment Of a Minor**

I give my permission for \_\_\_\_\_ to counsel/treat my minor child.

Parent/Legal Guardian's Signature	Date	Witness	Date
_____	_____	_____	_____

**Client's Bill of Rights**

- I have received a copy of the Client's Bill of Rights
- I am aware that Northland Counseling Services has a complaint/grievance procedure that I may use to address any concerns I may have.

Parent/Legal Guardian's Signature	Date
_____	_____