TALK NTAP
THERAPY FOR THE YOUNG

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New Client Form for Child/Youth

Child/Youth

Child/Youth's Name: _____ Sex: Male ____ Female ____

Date of Birth:_____ Age: _____

Address: _____

_____

School: _____

Medical Diagnosis: _____

Medication: _____

Other: _____

Parents/Caregivers

Parent/Carer Name 1: _____

Address: _____

_____

Phone: _____ Email: _____

Parent/Carer Name 2: _____

Address: _____

_____

Phone: _____ Email: _____

Emergency Details

Name: _____

Address: _____

Phone Number: _____

Issues

Description of why you are seeking therapy for your child/youth: _____

_____

_____

_____

_____

_____

_____

Previous treatment: _____

_____

_____

_____

What changes would you like to see for your child/youth: _____

_____

_____

_____

_____

_____

_____

Referred

Where did you find out about this service: _____

_____

Form Completed by:

Print Name: _____ Signature:_____ Date: _____