



*"Helping individuals, families, and communities strive for better health"*

**CLIENT PROFILE-Juvenile**

Name \_\_\_\_\_ Nickname \_\_\_\_\_  
(Last Name, First Name Middle Initial)

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Race \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_ Interests \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Please list a *private* number where we are able to leave messages that may contain information about your appointment \_\_\_\_\_  
Please only list one Initial

School Name \_\_\_\_\_

Problem Summary \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications \_\_\_\_\_

\_\_\_\_\_

Primary Care Physician (PCP)

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

**Emergency Contact**

In the case of an emergency, who should we contact?

Name \_\_\_\_\_ Number \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Internal Use Only

IDs	INS Card	QBP	S	U	E
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**CLIENT PROFILE continued-Juvenile**

**Pharmacy Information**

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How did you hear about us? *Circle one*

Newspaper   Magazine   Internet   Physician referral   Other \_\_\_\_\_  
(Please List)

**Referring Physician/Clinician Information**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Parent/Guardian Information**

Father's Name:			Mother's Name:			Guardian's Name:		
Employer:			Employer:			Employer:		
Occupation:			Occupation:			Occupation:		
Marital Status: Single/Married/Divorced/Widowed			Marital Status: Single/Married/Divorced/Widowed			Marital Status: Single/Married/Divorced/Widowed		
D.O.B _____			D.O.B _____			D.O.B _____		
Home Phone	Work Phone	Cell Phone	Home Phone	Work Phone	Cell Phone	Home Phone	Work Phone	Cell Phone

**Payment Agreement:**

I authorize payment of medical benefits to Mindfull Strategies, LLC or supplier for services rendered.

Sign (Parent or Guardian) \_\_\_\_\_ Date \_\_\_\_\_

I hereby agree to pay all applicable fees for services received at Mindfull Strategies, LLC. I understand that all payments are due in full at the time of service.

Sign (Parent or Guardian) \_\_\_\_\_ Date \_\_\_\_\_

Updated 3/08/2010