## Breathe Mind Body Therapy, LLC Joni Evans, LMFT, LCPC

## **Minor Client Information**

Client's Legal Name:					
	First	Middle	Last		
Date of Birth:		Age:			
Child's SSN:	Client's Cellphone:				
Client's Place of Employme	nt (if applicable):				
Present Address:					
Present Address:Str	eet	City	,	State	Zip
Home Telephone:	Cell:	Parer	nt's Work:		
Parent/Legal Guardian's Na	me:		Relationship:		
Parent/Legal Guardian's Na	me:		Relationship:		
School Attending:					
School Address:					
Str	eet	City  Contact Infor	State State	Zip	
Name:	Relationship:	Phone	: Pho	one:	_
Name:	Relationship:	Phone	: Pho	one:	_
Referral Source:		Agency:			
	Insura	nce Informati	on		
Name of <b>Health Insurance</b>	e Company:				
Address of Insurance Comp	pany:				
Telephone # of Insurance C	Company:				
Policy #:					
Policy Holder's Name (if ot	her than the client):				_
		First	Middle	Last	
Policy Holder's SSN:		Policy Holde	er's DOB:		
Policy Holder's Place of Em	ployment:				_
Policy Holder's phone #:		Policy Holder's Work phone #:			
Relationship to Policy Hold	er:				