AVENUES OF COUNSELING AND MEDIATION, LLC
230 South Court Street, Suite 5, Medina, OH 44256
843 North Cleveland-Massillon Road, Suite 6, Fairlawn, OH 44333
Phone (330-723-7977 Fax (330)725-5177

Child/Adolescent Client Information Sheet

Client's name: _____ Date_____
Birthdate:_____ Age: _____
Address:_____
City, State, Zip:_____
With whom does the child live:_____
Name and age of other children in home:_____
_____
Parent's marital/relationship status:_____
Custody arrangement in place:_____
Documentation provided to clinician regarding court order. Yes_____No_____
Child's current school and grade:_____

Biological Mother Name:_____DOB:_____
Address:_____
Phone Number: Home_____Cell_____Work_____
Stepfather Name:_____DOB:_____
Phone Number: Home_____Cell_____Work_____

Biological Father Name:_____DOB:_____
Address:_____
Phone Number: Home_____Cell_____Work_____
Stepmother Name:_____ DOB:_____
Phone Number: Home_____Cell_____Work_____

Legal Guardian Name:_____ DOB:_____
Relationship to child:_____
Address:_____
Phone Number: Home_____Cell_____Work_____

Guardian Ad Litem:_____
Address:_____
Phone:_____FAX:_____

Probation Officer Name:_____
Address:_____
Phone:_____FAX:_____

PLEASE READ AND SIGN CONSENT ON BACK OF PAGE

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Consent for Treatment of a Minor or Adult with Guardian

I _____bearing relationship of _____to
(Parent/Guardian name) (Custodial Mother, Father, Guardian)

_____, do hereby grant permission
(Child's name)

to_____ and Avenues of Counseling and Mediation, LLC.
(Clinician's Name)

To render the service or treatment necessary to the above mentioned client. The service or treatment is to include care essential for the client's condition. All treatment or any changes in treatment will be discussed with said parent/guardian, with the client's confidentiality upheld.

Signed:_____
Date:_____
Witness:_____

In compliance with the policy of Avenues of Counseling and Mediation, LLC, I agree that the adult bringing the child to the appointment will pay the copay or deductible expenses at the time of the visit. I further agree that reimbursement of any financial responsibility from the other parent will be my responsibility and will not involve Avenues of Counseling and Mediation, LLC.

Signed:_____
Date:_____
Witness:_____