Pittington Counseling Services

Building Stronger Lives Together
One Step At A Time

CLIENT VITAL STATISTICS

EMERGENCY INFORMATION FORM

DATE OF INITIAL APPOINTMENT::_____

CLIENT NAME_____
LAST FIRST MIDDLE

SOCIAL SECURITY NO: _____

DATE OF BIRTH: _____AGE:_____SEX:_____RACE:_____HEIGHT:_____

WEIGHT:_____COLOR OF HAIR:_____COLOR OF EYES:_____

ANY DISTINGUISHING MARK(S):_____

SPECIAL MEDICAL PROBLEMS AND ALLERGIES:_____

CURRENT GRADE LEVEL: _____Year Graduated _____GED: YES/NO

LAST SCHOOL ATTENDED:_____

MOTHER'S NAME:_____

ADDRESS:_____

CITY: _____STATE:_____ZIP:_____COUNTY:_____

HOME PHONE #:_____WORK PHONE #:_____

CELL PHONE #:_____PAGER #:_____

FATHER'S NAME:_____

ADDRESS:_____

HOME PHONE #:_____WORK PHONE #:_____CELL:_____

NAME OF LEGAL GUARDIAN(S):_____CONTACT #:_____

REFERRAL SOURCE:_____