Youth For Tomorrow
Joe Gibbs Founder
OUTPATIENT SERVICES

14000 Crown Court, Ste. 101
Woodbridge, VA 22193
Phone # 703-396-7215
Fax # 571-285-5686

9720 Capital Court, Ste. 302
Manassas, VA 20110
Phone # 703-396-8618
Fax # 571-364-8913

7130 Heritage Village Plz, Ste. 102
Gainesville, VA 20155
Phone # 571-921-4812
Fax # 703-743-1688

6800 Backlick Road, Ste. 300
Springfield, VA 22150
Phone # 703-310-7449
Fax # 866-295-9344.

CLIENT CONTACT INFORMATION SHEET

1. **Name**:_____/_____/_____/_____
   LAST / FIRST / MIDDLE INITIAL / SUFFIX

2. **Social Security #**: _____

3. **Gender**: _____

4. **Address**: _____
   STREET
   _____/_____/_____
   CITY / STATE / ZIP

5. **Date of Birth**: _____/_____/_____ **Age**: _____
   MONTH / DAY / YEAR

6. **Telephone Numbers**: _____ _____ _____
   INCLUDE AREA CODE HOME WORK CELL / OTHER

7. **May Youth For Tomorrow leave a message on the phone number(s) provided** _____Yes_____No

   - If Yes, check all that apply. Home____ Cell Phone ____ Voice Only_____ Text Only ____Voice and Text ____
   - If No, please provide an alternate phone on which we may leave a message: _____

8. **Race** (please identify): _____**Ethnicity**: _____

9. **Marital Status**: _____Never Married _____Married _____Separated _____Divorced _____Widowed

10. **Are you Pregnant?** ___Yes ___No

11. **Emergency Contact**:_____/_____/_____
    Name / Relationship / Home Phone# (include area code)
    _____/_____
    Address (if different) (Street) (City) (State/Zip) Work Phone # (include area code)

12. **Primary Caregiver**:_____/_____/_____
    (if under age 18) Name / Relationship / Home Phone# (include area code)
    _____/_____
    Address (if different) (Street) (City) (State/Zip) Work Phone # (include area code)

13. **If the Client is a Minor**, is there any other individuals(s) that has legal custody (rights) of said client of any kind? __Yes __No
    - If "Yes": Is the additional individual(s) who has legal rights in regards to this minor, fully in support of the aforementioned minor receiving mental health treatment services with Youth For Tomorrow? __Yes __No
    - If "Yes": Please provide the following information regarding said individual:

      a. (print):_____/_____/_____/_____
      Name / Relationship / Contact Phone# / Fax # (include area code)

      b. Explanation of the legal custodial arrangement for the minor: _____

      _____

      _____

14. **If the Client is a Minor**, please list: a. School attended: _____ b. Grade _____

15. **If the Client is an Adult,** is there a Legally Authorized Representative or Court Appointed legal guardian? __Yes __No

    If yes, please complete (print):_____/_____/_____/_____
    Name / Relationship / Contact Phone# / Fax # (include area code)

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ACKNOWLEDGMENT OF RIGHT FOR PARENTS OF MINOR CHILDREN

I understand that pursuant to Virginia Code 54.1-2969(E), my minor child shall be deemed an adult for the purpose of consenting to medical or health services needed in the case of outpatient care, treatment, or rehabilitation for mental illness or emotional disturbance.

16. Military

__No Military Status __Active Duty __Armed Forces Reserve

__National Guard Discharged (any type) __Armed Forces or National Guard Retired __Armed Forces or National Guard

__Dependent Family Member of Armed Forces or National Guard

17. Primary Insurance _____/_____/_____
Primary Insurance Provider | Medical ID # | Group #

18. Secondary Insurance _____/_____/_____
Secondary Insurance Provider | Medical ID # | Group #

19. I have been given a copy of the YFT Orientation Packet, including Notification of my Rights and Privacy Notice.
(Sign and date below.)

_____/_____
Signature of Responsible Party **Date**