

YOUTH DYNAMICS
APPLICATION FOR YDI SERVICES

Client's Name: _____

SSN: _____ DOB: _____ Age: _____ Sex: _____

Parent or Legal Guardian: _____

Spouse: _____

Address: _____ City _____ Zip _____

Phone Number: _____ Work Number: _____

Has the client received prior mental health services? Yes No

If so, what services were received? _____

Has the client been on medications for mental health purposes? Yes No

If so, what medications were / are taken? _____

Does the client have insurance? Yes No Does the client have Medicaid/CHIP? Yes No

Name of Company: _____ Insurance ID Number: _____

Other Method of Payment: _____

What are the presenting problems (*explosive behavior; physical, emotional, or sexual abuse, depression, etc*)?

How can we help you? _____

Please return to: **(Insert local Service Area/Group Home Address/Phone #'s.)**

How did you hear about Youth Dynamics? _____

Signature of Client / Parent / Legal Guardian

Date