intuition
wellness center
LEARN. GROW. THRIVE.

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www.intuitionwellness.com

CLIENT INFORMATION - YOUTH

Client Name: ______________________ **Date of Birth:** ______________

Preferred First Name: ______________________

Sex Assigned at Birth (designated on birth certificate/per healthcare insurance)**:** ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Cohabitating ☐ Other

Employment: ☐ Full-time Student ☐ Part-time Student ☐ Employed ☐ Unemployed/Other

Address: ______________________________________
Street City State Zip

Primary Contact

Name: ______________________ **Relationship to Client:** ☐ Parent

☐ Stepparent ☐ Guardian ☐ Emergency Contact ☐ Other: ______________

Address: ☐ Same as client ______________________________________
Street City State Zip

Preferred Phone: ______________ **Preferred Email:** ______________

Voice messages ☐ Yes ☐ No Email messages ☐ Yes ☐ No Email appt. reminders ☐ Yes ☐ No

Person(s) Responsible for Payment: ______________________

Secondary Contact

Name: ______________________ **Relationship to Client:** ☐ Parent ☐ Stepparent

☐ Guardian ☐ Emergency Contact ☐ Other: ______________

Address: ☐ Same as client ______________________________________
Street City State Zip

Preferred Phone: ______________ **Preferred Email:** ______________

Emergency/Guardian/Payment Contact: Voice messages ☐ Yes ☐ No Email messages ☐ Yes ☐ No

Primary Insurance

Insurance: ☐ BCBSAZ ☐ Aetna ☐ Other: ______________

Subscriber's Name: ______________________ **Subscriber's Date of Birth:** ______________

Sex Assigned at Birth (designated on birth certificate/per healthcare insurance)**:** ☐ M ☐ F

Subscriber's Relationship to Client: ☐ Self ☐ Parent ☐ Stepparent ☐ Guardian ☐ Emergency Contact

☐ Spouse ☐ Life Partner ☐ Other: ______________ **Company/School:** ______________

- continued -

Address: ☐ Same as client ____
Street City State Zip

Preferred Phone: ______________________ **Preferred Email:** ______________________________

Secondary Insurance ☐ Yes ☐ No **Insurance:** ☐ BCBSAZ ☐ Aetna ☐ Other: ____________

Emergency Contact

Name: ______________________________

Relationship to Client: ☐ Spouse ☐ Partner ☐ Parent ☐ Other: ______________________

Address: ☐ Same as client ____
Street City State Zip

Preferred Phone: ______________________ **Preferred Email:** ______________________________

Voice messages ☐ Yes ☐ No *Email messages* ☐ Yes ☐ No

Primary Care Physician

Name: ____________________ **Practice:** ____________________ **Phone:** ______________

☐ **Yes! Please email Intuition Wellness Center parenting news and wellness program updates.**

"Intuition Wellness Center provides integrated clinical services and wellness programs to clients without discrimination on the basis of gender identity and expression, sex, sexual orientation, race, color, national or ethnic origin, citizenship, marital status, religious beliefs, age, ability, appearance or any other characteristic protected under applicable federal or state law."

Additional Information - Optional

While you are not required to answer the following questions, knowing more about the different facets of your identity helps Intuition Wellness Center team members support you through services that are truly tailored and inclusive. You may prefer to provide additional information privately during your appointment.

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/FTM ☐ Transgender Female/MTF

☐ Non-Binary ☐ Genderqueer ☐ Unknown ☐ Choose not to disclose ☐ Other______________

Sexual Orientation: ☐ Lesbian/Gay/Homosexual ☐ Straight/Heterosexual ☐ Bisexual ☐ Unknown

☐ Choose not to disclose ☐ Other: ______________________________

Pronoun: ☐ they/them ☐ he/him ☐ she/her ☐ Other: ______________________________

Race: *Please check all that apply*

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic/Latino-a
☐ Native Hawaiian or Other Pacific
☐ White/Caucasian
☐ Other: ______________________________

Ethnic Identity: ____

Primary Language Spoken at Home: ______________________