



# Patti's Place

Supportive Counseling for  
Families that have been touched  
by Childhood Cancer

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## CLIENT INFORMATION

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Client Name

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Client Address

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If client is a minor, Parent or Guardian's Name

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Parent or Guardian's Address (if different from above)

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Home Telephone

Work Telephone

Date of Birth

Male/Female

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Employer Name

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Employer Address

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Emergency Contact Name

Emergency Contact Telephone

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Emergency Contact Address



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## CLIENT INFORMATION (cont.)

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Physician Name

Physician Telephone

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Physician Address

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Approximate date of last physician visit

Are you taking medications?

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If yes, please specify what medications and for what purpose:

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Are you, or have you been, under the care of a mental health counselor (psychologist, psychiatrist, social worker, etc.)?

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Do you have any significant health problems?

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If yes, please explain:

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Relationship to childhood cancer patient

Childhood cancer diagnosis

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Your age at time of treatment

Patient age at time of treatment

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Approximate dates of treatment



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## CLIENT INFORMATION (cont.)

Please provide a brief history of treatment, (include relapses, significant complications of late effects due to treatment):

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Please describe briefly your concerns or questions that have brought you to Patti's Place:

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Signature of Client or Parent/Guardian

Date

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Signature of Patti's Place Counselor

Date