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Instructions: Please fill out this form as completely as possible and please print or write legibly. If you need more room to complete any section, continue writing on the back of that page. For couples and family therapy, each person should complete a set of all four pages. If certain questions do not apply to you, write NA. If you have questions or concerns about any items, please discuss them with your clinician. All information is CONFIDENTIAL.

Child/Adolescent's Name (First, Middle Initial, Last)

Child's Preferred Pronoun(s): _____

Parent(s): _____

Step-Parents: _____

Address _____

City/State/Zip _____

Phone #s: Home _____

Work _____ Cell: _____ Ok to text? _____

Email: _____ Ok to email statements/invoices? _____

Do you want us to use discretion when calling you or leaving messages at any of the phone #s?

No ___ Yes ___ (If Yes, please be specific) _____

Age _____ Birth Date _____ Social Security # _____

School: _____ Grade: _____

Parent(s):

Single ___ Married ___ (# years _____) Partnered ___ (# years _____) Separated ___ Divorced ___

Widowed ___ Other ___ (specify) _____

Names and ages of other children _____

Significant medical problems your child has or had: _____

Current Physician: _____ Ph# _____

Current medications child is taking _____

If your child has had any previous mental health and/or substance abuse treatment (outpatient and inpatient), list the type and approximate start and end dates for each:

If you are currently working with any other mental health professionals (including psychiatrists), list their names, profession, phone number and address and length of time you have been working with them:

SIGNATURES

Please sign in all the appropriate places:

ALL CLIENTS SIGN HERE

I certify that all the information I have provided above is accurate to the best of my knowledge. If any of the information changes I will provide updated information to your clinician as soon as possible.

Client Signature

Date