

PARENT INFORMATION & CONTACT FORM

Today's date: _____

Note: If you have received treatment here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Spouse's Name: _____

Contact Info if Appropriate or Different: _____

Child's Name: _____ Date of birth: _____ Age: _____

Child's Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Work phone _____ Cell _____

*Calls will be discreet, but please indicate any restrictions:

B. Insurance Information:

Provider _____ Policy # _____

Contact Phone # _____ (so that we may assist with obtaining out-of-network benefits)

B. Referral: Who gave you our name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? Yes No

How did this person explain how I might be of help to you? _____

C. Your medical care: Does your child have a primary care physician?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you entered treatment with me for psychological problems with a medical component, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

PARENT INFORMATION & CONTACT FORM

PARENT INFORMATION & CONTACT FORM

D. Child's School:

Name of School: _____ Grade: _____

Address: _____ Phone: _____

Special Education Services (describe): _____

*Note: Permission to contact requires your signature on a separate "release of information form"

E. Chief Concern:

Please describe the main difficulty that has brought you/your child to see us: _____

F. Treatment

1. Has your child ever received psychological or psychiatric or counseling services before? No Yes If yes, please indicate:

| When? | From whom? | For what? | With what results? |
|-------|------------|-----------|--------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

2. Has your child ever taken medications for psychiatric or emotional problems? No Yes If yes, please indicate:

| When? | From whom? | Which medications | For what | With what results? |
|-------|------------|-------------------|----------|--------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

G. Marital & Family Status:

Married: No Yes How long: _____?

Divorced: No Yes Date of divorce: _____?

Separated: No Yes Date of Separation: _____?

Custody/ Visitation Arrangements: _____

Siblings (age & gender): Sisters: _____ Brothers: _____

PARENT INFORMATION & CONTACT FORM