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Please complete one page for each child/adolescent.
Please have teens (13-18) complete the form themselves if applicable.

Child/Teen Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____

Address (Home) – may I send mail here? YES NO Phone #s – may I leave a message at this #? YES

Street: _____ Home: _____ YES NO

City/St.: _____ Cell: _____ YES NO

Zip: _____ Other: _____ YES NO

Email: _____ May I email you? YES NO

Parent/Guardian: _____ Phone # _____

School Attending: _____ Grade: _____

Teacher/Counselor Name: _____

Primary Care Physician's Name: _____ Phone #: _____

Date of last physical exam: _____

May I contact the physician if necessary? YES NO

Please provide parent/guardian signature indicating consent: _____

Please provide teen signature indicating consent: _____

Please list any medical/health issues currently being treated or that have been treated in the past:

Please list any medications (prescription and non-prescription) that are being taken:

Type	Dose	Reason
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Previous counseling/therapy? YES NO

Dates Therapist's Name

Please indicate current use and frequency of the following substances:

	More than once a day	Once a day	Once every 2-3 days	Weekly	Monthly	Yearly or less	Never
Alcohol							
Non-prescription Drugs							
Nicotine							
Caffeine							
Prescription Drugs							

Please explain who lives in the household and their relationships:

Please share the reasons for seeking therapy at this time:

Person to contact in case of emergency:

Name: _____ Phone: _____

Relationship: _____

Are biological parents divorced or separated? YES NO

If yes, please list the contact information of the other parent:

Name _____ Cell #: _____

Address: _____ Work #: _____

_____ Home #: _____

Do parents share joint custody? YES NO

Please explain the current living arrangements/visitation schedule if sharing time in two homes:

Thank You!