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PATIENT INFORMATION FOR MINORS

CHILD'S NAME: _____

CHILD'S ADDRESS: _____
STREET APARTMENT # CITY STATE ZIP

CHILD'S BIRTHDAY: _____ PLACE OF BIRTH: _____

School: _____
Grade School Name School District

Father's Name: _____

Mother's Name: _____

Parent's Marital Status: Married Separated Divorced Since _____

Father's Address: _____
Street Apt.# City State Zip

Mother's Address: _____
Street Apt.# City State Zip

Mother's Home Telephone Number: _____ Father's Home Telephone Number: _____

Mother's Work Telephone Number: _____ Father's Work Telephone Number: _____

Mother's Employer: _____ Father's Employer: _____

Mother's Occupation: _____ Father's Occupation: _____

PLEASE LIST THE NAMES OF THIS CHILD'S BROTHERS, SISTERS, STEP SIBLINGS, HALF SIBLINGS WHETHER LIVING OR DEAD, THE APPROXIMATE AGE OF EACH, AND WHERE THEY RESIDE:

| NAME | AGE | PLACE OF RESIDENCE | RELATIONSHIP TO ME |
|-------|-------|--------------------|--------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Who is this child's physician? _____
First Name Last Name Address

Is this child currently receiving medical treatment: ? YES NO If yes, briefly describe _____

Is this child currently receiving counseling or psychotherapy treatment? YES NO

If yes, briefly describe:

Please list all the mental health officials the child has consulted in the last five years:

Name Location Approximate dates

WHO REFERRED YOU
TO THIS PRACTICE? _____

MAY WE CONTACT THAT PERSON TO THANK
HIM/HER FOR THE REFERRAL? YES NO

Custodial Parent's Signature

Custodial Parent's Social Security Number

Date