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# CLIENT INFORMATION

Child's name______________________________________________________

Child's date of birth________________________________________________

Parents'/guardians names___________________________________________

Parent/Guardian Relationship Status (please circle):
Single Married Divorced Separated Widowed Domestic Partner

Child lives with (please circle) mother father both other*
*please explain any special circumstances__________________________

Mother's Address__________________________________________________

Father's
Address (if different)_______________________________________________

| Parent/Guardian Phone Numbers: | Okay to call? | Okay to leave message? |
|---|---|---|
| Home:_________________ | Yes/No | Yes/No |
| Work:_________________ | Yes/No | Yes/No |
| Cell:__________________ | Yes/No | Yes/No |

| Parent/Guardian Phone Numbers: | Okay to call? | Okay to leave message? |
|---|---|---|
| Home:_________________ | Yes/No | Yes/No |
| Work:_________________ | Yes/No | Yes/No |
| Cell:__________________ | Yes/No | Yes/No |

Parent/Guardian email address(s):_____________________________________
_____________________________________________________________________

Child's School______________________ Grade______________________

Please describe the reason(s) for your child seeking treatment at this time:_____________

________________________________________________________________________

________________________________________________________________________

Child's Primary Care Physician and Phone Number______________________________

_______________________________________________________________________

Mother's Employer__________________________________________

Father's Employer___________________________________________

**Insurance Information**

Primary Health Insurance Company:__________________________________________

Insurance Company Address &
Phone Number________________________________________________________

Group #_________________ Member #______________________

Insured Name_________________________________________________________

Insured date of birth:___________________________________________________

Insured Address_______________________________________________________

Patient's relationship to insured____________________________________________