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PATIENT INFORMATION: CHILD (MINOR)

Patient Name: _____ Date of Birth: _____

Home Address: _____

_____

Mother's Name: _____ Spouse/Partner's Name: _____

Mother's Address: _____ City: _____ Zip: _____

Mother's Employer: _____ Work #: _____ Home/cell: _____

Father's Name: _____ Spouse/Partner's Name: _____

Father's Address: _____ City: _____ Zip: _____

Father's Employer: _____ Work #: _____ Home/cell: _____

Please indicate the telephone number you wish me to use to contact you

Emergency Contact: Name: _____ Phone: _____

Relationship to patient: _____

_____

Any medications, including doses and any supplements or vitamins:_____

_____

Any known allergies: _____

Brief description of why you are seeking therapy for your child/teen: _____

_____

_____

Other pertinent information: _____

_____

If parents are divorced or separated, please bring a copy of custody papers to the first appointment.