



CHILD AND FAMILY PRACTICE
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Client's Name: _____ Birth Date: __/__/__ Age _____

Home Address: _____ City: _____

State: ____ Zip _____ Home Phone (_____) _____ - _____ email: _____

Marital Status: Single Married Divorced Spouse's Name: _____

Employer's Name: _____

Employer Address: _____ City: _____

Employer State: ____ Zip _____ Work Phone (_____) _____ - _____

Email address: _____ Cell Phone (_____) _____ - _____

Occupation: _____ Call at Work? Yes No

Academic Status: Are you currently a student? Yes No Full Time Part Time

What is your highest level of education? _____

Where should confidential information be left? _____

Spouse (if none, Nearest Relative): _____ Relation: _____

Home Address: _____ City: _____

State: ____ Zip _____ Home Phone (_____) _____ - _____

Children (names/ages): _____

Other:

Name of Referral Source: _____

Physician's Name: _____ Phone (_____) _____ - _____

Should I send summary reports to your doctor/other professional? Yes No If yes, provide address.

Physician's Address: _____ City: _____

Physician's State: ____ Zip _____

Emergency Contact: _____ Phone (_____) _____ - _____

Authorization

1. I authorize the release of any medical or other information to my insurance company in order to process claims.
2. I agree to pay for all services, even if they are not covered by my insurance plan, e.g., report preparation, record reviews, and extended phone calls.

Signature: _____ Date: __/__/__

Medical History:

List injuries and/or operations

Age

Severity

Hospitalization
(Yes/No)

Is medication taken regularly for any reason? Yes No

If yes, what kind? _____

Is appetite good? Yes No

If no, describe: _____

Are you sleeping well? Yes No

If no, describe: _____

Are there any other health concerns you have? _____

Have you had previous counseling or assessment? Yes No

If yes, describe: _____

What else you would like me to know about you at this time? _____
