



CHILD AND FAMILY PRACTICE
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Mother's/Wife's Name: _____ Birth Date: ___/___/___ Age: _____
Home Address: _____ City: _____
State: ___ Zip _____ Home Phone (_____) _____ - _____
Marital Status: Single Married Divorced Spouse's Name: _____
Employer's Name: _____
Employer Address: _____ City: _____
Employer State: ___ Zip _____ Work Phone (_____) _____ - _____
Occupation: _____ Call at Work? Yes No
What is your highest level of education? _____
Cell Phone: (_____) _____ - _____ Email Address: _____

Father's/Husband's Name: _____ Birth Date: ___/___/___ Age: _____
Home Address: _____ City: _____
State: ___ Zip _____ Home Phone (_____) _____ - _____
Marital Status: Single Married Divorced Spouse's Name: _____
Employer's Name: _____
Employer Address: _____ City: _____
Employer State: ___ Zip _____ Work Phone (_____) _____ - _____
Occupation: _____ Call at Work? Yes No
What is your highest level of education? _____
Cell Phone: (_____) _____ - _____ Email Address: _____

Child's Name: _____ Age: _____
Birth Date: ___/___/___ Sex: M F
School: _____ Grade: _____
Home Address: _____
City: _____ State: ___ Zip _____ Phone (_____) _____ - _____

Child's Name: _____ Age: _____
Birth Date: ___/___/___ Sex: M F
School: _____ Grade: _____
Home Address: _____
City: _____ State: ___ Zip _____ Phone (_____) _____ - _____

For additional children, please use back of page.

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 (____) ____ - ____

Where should confidential information be left?: _____

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: ____ / ____ / ____

What else you would like me to know about your marriage/family at this time? _____

What would you like to see as the result of counseling? _____
