

EMOTIONAL RESOURCE CENTER
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Child/Teen – New Client Information

A. Identification

Child's Name _____ Birth Date _____ Age: _____
Place of Birth _____ Lives with: _____
School Attending _____ Grade _____

Mother's name: _____ Birth Date: _____ Home Phone _____
Address: _____ Zip Code _____
Currently employed: No Yes At: _____
Work Phone _____ Cell: _____
Social Security Number: _____

Father's name: _____ Birth Date: _____ Home Phone _____
Address: _____ Zip Code _____
Currently employed: No Yes At: _____ Work Phone _____
Work Phone _____ Cell: _____
Social Security Number: _____

Parents are currently: Married Divorced Remarried Never Married Other: _____
Child's custodian/guardian is: _____

Stepparent's name: _____ Birth Date: _____ Home Phone _____
Address: _____ Zip Code: _____
Currently employed: No Yes At: _____
Work Phone _____ Cell: _____
Social Security Number: _____

B. Health

List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, periods of loss of consciousness, convulsions/seizures, and other medical conditions. _____

Is Child on any Medications? _____ If yes, please state name, dosage, and reason taken _____

Physician Name _____ Phone Number _____

Primary Insurance Company: _____
Mental Health Ins. Phone Number _____ Employer/Group# _____
Policy Holder: _____ Member ID Number _____

C. Household Members:

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Source of Referral: _____

Please describe briefly your reason for seeking therapy:

PLEASE NOTE:

Your appointment time is reserved exclusively for you. **Please call eight hours in advance to reschedule your appointment if a change is needed. A fee equivalent to your co-pay and what your insurance would pay or \$75.00, whichever is the lower of the two, is assessed for late cancellations or missed appointments.**

Signature _____

Date: _____