Child Background Form

Today's Date:_____

Patient Name: _____ DOB:_____

Forms completed by (if not self): _____

Patient Address: Sex: Male Female

_____

(Street/Apartment) (City) (State) (Zip)

Contact Number: (_____)_____ Name/Relation _____

*Please indicate where we may leave you a voicemail with an asterisk**

E-mail Address: _____

Current School: _____ Grade:_____

Religion: _____ Ethnicity: _____

Referral Source:

Doctor_____

(Name) (Address) (Phone)

Friend or relative_____

Other (please specify)_____

In Case of Emergency Contact:

Name: _____ Relationship to you: _____

Phone Number(s): _____

Parents are (circle one):

Never Married Married Separated

Divorced (Since:_____) Deceased (Name(s) & Date(s): _____)

Parents' Information:

Parent Name (1):_____ DOB:_____

Marital Status: _____ Spouse Name: _____

Continued on next page

Address: *(Write "Same" if same as patient's address)*

_____

(Street/Apartment) *(City)* *(State)* *(Zip)*

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Other Phone: (_____)_____

*Please indicate where we may leave you a voicemail with an asterisk**

E-mail Address: _____

*Please consider the sharing of confidential information (appointment times, names, etc.) with this email address**

Occupation/Place of Business: _____

Highest Level of Education Achieved & Date of Completion: _____

Religion:_____ Ethnicity:_____

Marital Status: _____ Spouse Name: _____

Parent Two

Parent Name (2):_____ DOB:_____

Marital Status: _____ Spouse Name: _____

Address: *(Write "Same" if same as patient's address)*

_____

(Street/Apartment) *(City)* *(State)* *(Zip)*

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Other Phone: (_____)_____

*Please indicate where we may leave you a voicemail with an asterisk**

E-mail Address: _____

*Please consider the sharing of confidential information (appointment times, names, etc.) with this email address**

Occupation/Place of Business: _____

Highest Level of Education Achieved & Date of Completion: _____

Religion:_____ Ethnicity:_____

Siblings of Patient

Name	Sex	Date of Birth	Where Resides

_____

_____

_____

_____

_____

_____

Please describe any known health problems, medical problems, medical issues, past hospitalizations, surgeries, developmental problems, etc. for the patient:

_____

_____

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_____

Please describe any significant mental or physical health issues of patient's family members (parents, siblings, grandparents, aunts, uncles, children, spouse, etc.)

_____

_____

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_____

Current/Previous Psychological Evaluations and Treatments:

Name of Doctor, Agency, Hospital, etc.	City, State	Date(s)	Briefly explain services provided and outcome

Additional information not previously mentioned:

_____

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