



CHILD INFORMATION FORM

Child's Full Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Address - Street, City, State, Zip: _____

Child's School: _____ Grade: _____

Home phone: _____ May we call you at home? _____ May we leave a message? _____

Parent(s)/Guardian(s) with whom the child lives:

Name: _____ Relationship: _____ Age: _____ Occupation: _____

Place of Employment: _____ Highest Level of Education: _____

Work phone: _____ May we call you at work? _____ May we leave a message? _____

Cell phone: _____ May we call you on cell? _____ May we leave a message? _____

Name: _____ Relationship: _____ Age: _____ Occupation: _____

Place of Employment: _____ Highest Level of Education: _____

Work phone: _____ May we call you at work? _____ May we leave a message? _____

Cell phone: _____ May we call you on cell? _____ May we leave a message? _____

Other persons living in the home:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent, guardian or sibling(s) not living in the home:

Name: _____ Relationship: _____ Age: _____ Occupation: _____

Address - Street, City, State, Zip: _____ Phone: _____

Name: _____ Relationship: _____ Age: _____ Occupation: _____

Address - Street, City, State, Zip: _____ Phone: _____

Any medical difficulties/allergies? _____ If yes, what? _____

Is the child currently on any medication? _____ If yes, what? _____

Prescribing physician: _____

Has counseling been sought before? _____ Where? _____

Was it helpful? _____

Who referred you here? _____

I give you permission to treat my child: _____

Signature

Relationship