CHILD/ADOLESCENT CLIENT REGISTRATION FORM

Date: _____

Client Name: _____ DOB: _____ Age: ____ Gender: _____

Address: _____

Client's Cell Phone: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

School: _____ Grade: _____

	Parent/Guardian 1	Parent/Guardian 2
Name		
Relationship to Client		
Home Phone		
Cell Phone		
Email Address		

Do all parents/legal guardians know about psychology services? □ Yes □ No

Who lives with the client: _____

_____

Who Referred You: _____

Reason for Your Visit: _____

_____

_____

Medical and Mental Health History

Does the client have any acute or chronic medical conditions (e.g., asthma, diabetes, cancer) □ Yes □ No

If yes, please list the condition(s) and date of diagnosis: _____

_____

Current Medications: □ None □ Yes: _____

_____

Allergies: □ None □ Yes: _____

Has the client participated in mental health services in the past? □ Yes □ No

If yes, please list most recent provider and any prior diagnoses: _____

_____