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CLIENT REGISTRATION: CHILD FORM

1. Personal Information **Today's Date:**_____

Child's Full Name: _____

Date of Birth:_____ Age:_____ Family's Religious Affiliation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Child/Teen Cell: (_____) _____

Parent Cell: _____/Other: _____

e-mail (if applicable): _____

Education: Grade: _____ School:_____

Favorite/Best Subject: _____

Least Favorite Subject: _____

Activities involved in (sports; dance) _____

2. Responsible Party Information

Name of Responsible Party: _____

Address (if different than client's)_____

Relationship:_____ Birth Date: _____ SS# _____

Place of Employment: _____ Length of Employment: _____

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

Cell Phone: (_____)_____ Child's Legal Guardians: _____

PAYMENT AUTHORIZATION

I understand that it is my responsibility to pay for the fee established for professional services rendered to the above client. I hereby authorize payment directly to Adria O'Donnell, Psy.D. In addition, 24 hours notice is required to cancel an appt. in order to avoid late charges.

Signature of Responsibly Party _____ Date: _____

3. Current Living Situation

Please fill in the chart below, including everyone who currently lives in your home.

First Name	Age	Relation to Child	Grade in School/Occupation

5. Family Background: Please circle and fill in Blanks

Parents:

Father Living If alive, age?_____

Deceased If deceased, age at time of death _____

Occupation _____

Mother Living If alive, age?_____

Deceased If deceased, age at time of death _____

Occupation _____

Where was your child born? _____

Where has your child lived? _____

Did you have frequent moves? YES NO If so, briefly describe _____

_____

_____

6. Health History

Please list any serious illnesses that your child *currently* has (i.e.: diabetes, asthma):

_____

_____

_____

Please describe any medical issues your child has had in the past. Include all major surgeries:

_____

_____

_____

_____

Please list any medication that your child *currently* takes (prescribed or over the counter.)

Medication Name	**Dosage**	**Reason for Medication**

Prescribing Doctor: _____

*Doctor's Contact Information:_____

*(Collaboration among professionals working with you will assist in your care. A signed Authorization form will be requested to consult with this professional.)

7. Psychological History

Is your child currently seeing a counselor/therapist? YES NO

Has s/he ever been in therapy before YES NO

If so, previous therapist(s): _____

If so, briefly describe the issues of your previous counseling _____

_____

_____

Did you find the counseling helpful? YES NO Previous Hospitalizations YES NO

If so, when: _____ Where:_____

8. Current Situation

Please briefly describe the reasons for seeking help at this time: _____

_____

_____

_____

When did these issues arise? _____

Please describe some goals you hope to achieve in coming here: _____

_____

_____

_____

Please include any additional information that might be helpful in this process: _____

_____

_____

_ _____