NEW CLIENT REGISTRATION (CHILD/TEEN)

Date: ________________ How did you find our practice? ____

CLIENT INFORMATION

Child's Full Name: _______________________________________ Preferred Name: _________________

Full Address: ____

Date of Birth: _____________________ Child's Sex: ___________ Gender/Pronouns: _______________

School: ____ Town: ___________________ Grade: ________

Race and Ethnicity: ____

PARENT/CAREGIVER/LEGAL GUARDIAN #1 INFORMATION:

Parent/Caregiver #1 Name: ____

Date of Birth: ____ Sex: ____________________

Address: ____

Home Phone: __________________________________ Cell Phone: _______________________________

Work Phone: ___________________________________ Email: ___________________________________

Permission to Contact:

[ ] Email OK [ ] Text/Voicemail OK [ ] Text Only OK [ ] Voicemail Only OK

[ ] Other: ____

Relationship to the Child: ____

PARENT/CAREGIVER/LEGAL GUARDIAN #2 INFORMATION: (if applicable)

Parent/Caregiver #1 Name: ____

Date of Birth: ____ Sex: ___________________

Address: ____

Home Phone: ________________________________ Cell Phone: _____________________________

Work Phone: _________________________________ Email: _________________________________

Permission to Contact:

[ ] Email OK [ ] Text/Voicemail OK [ ] Text Only OK [ ] Voicemail Only OK

[ ] Other: ____

Relationship to the Child: ____

WHO ELSE LIVES IN YOUR HOME? (Name, Age, Relationship to Client)

Name	Age	Relationship

EMERGENCY CONTACT:

[ ] Parent/Caregiver #1 [ ] Parent/Caregiver #2 [ ] Other: (add information below)

Name: _____________________________ Phone: _______________Relationship: _______________

FINANCIALLY RESPONSIBLE PARTY:

[ ] Parent/Caregiver #1 [ ] Parent/Caregiver #2 [ ] Other: (add information below)

Name: _____________________________ Phone: _______________Relationship: _______________

INSURANCE INFORMATION: (Please provide a copy of the front and back of your insurance card.)

Primary Insurance:

Insurance Plan: ________________________________ Insurance Phone Number ___________________

ID# ________________________ Group# ___________ Employer: ________________________________

Name of Primary Insured: __________________________________ Date of Birth: ___________________

Secondary Insurance:

Insurance Plan: ________________________________ Insurance Phone Number ___________________

ID# ________________________ Group# ___________ Employer: ________________________________

Name of Primary Insured: __________________________________ Date of Birth: ___________________

CLIENT'S MEDICAL AND PSYCHOTHERAPY HISTORY:

Previous psychotherapy history: ____

Pediatrician: ____ Phone: ________________________

Psychiatrist (if any): _______________________________________ Phone: ________________________

Other Providers (e.g., occupational therapist, speech therapist, psychologist, etc.):

Provider Name: ____ Phone: ________________________

Provider Name: ____ Phone: ________________________

Health Issues or Allergies: ____

Medications: ____

THERAPY GOALS:

Please give a brief description of your primary concern.

____

____

What do you hope to achieve or gain with therapy?

____

I am acknowledging that the information I provided here is true to the best of my knowledge.

Printed Name and Signature: ____ Date: ____________