



CHILD/ADOLESCENT INTAKE FORM

NAME _____ **DATE** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

HOME PHONE _____ **CELL PHONE** _____

DATE OF BIRTH _____ **SOC. SEC. #** _____

SCHOOL _____ **GRADE** _____

1ST INSURANCE COMPANY _____ PHONE _____

BEHAVIORAL/MENTAL HEALTH DIV. _____ PHONE _____

POLICY # _____ POLICY HOLDER _____

2ND INSURANCE COMPANY _____ PHONE _____

BEHAVIORAL/MENTAL HEALTH DIV. _____ PHONE _____

POLICY # _____ POLICY HOLDER _____

MOTHER'S NAME _____ DOB _____ PHONE (c) _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ PHONE (w) _____

SOC. SEC. # _____ PHONE (h) _____

FATHER'S NAME _____ DOB _____ PHONE (c) _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ PHONE (w) _____

SOC. SEC. # _____ PHONE (h) _____

Email(mother) _____ Email(father) _____

Do we have permission to leave a detailed message regarding appointments, etc. on your
Cell Phone Y N **Home Phone** Y N **Email** Y N

REFERRED BY _____ PHONE _____

ADDRESS _____

REASON FOR REFERRAL _____

Dx:

For office use only

HCVA:

For office use