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 only

HCVA: For office use