The Therapeutic Center for Children and Families

Today's Date: _____/_____/_____

Name: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Provide the following numbers and check the best number(s) to reach you:

☐ Home#(s):_____ ☐ Work#(s):_____ ☐ Mobile#(s):_____

Date of Birth: _____/_____/_____ Age: _____ Birth Place: _____

If applicable, date of arrival in USA: _____/_____/_____

Religion: _____

If applicable, please include your:

Occupation: _____ Hours/Days of Work: _____

Employer: _____

Current School: _____ Grade/Year: _____

Please circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12

College: 1 2 3 4 degree: _____ Grad/Post-grad degree(s): _____

Please answer the items that apply to your marital situation:

Current marital status: _____ # years married: _____

Name of spouse: _____

Date separated: _____/_____/_____ Date divorced: _____/_____/_____ Date widowed: _____/_____/_____

Previous marriages? Y N if yes, provide dates: _____

Children (if applicable) with names and ages: _____

Please answer the following items regarding your parents:

Current marital status: _____

Is your mother living? Y N if not, date deceased: _____/_____/_____

Is your father living? Y N if not, date deceased: _____/_____/_____

PLEASE PROVIDE AT LEAST 48 HOURS NOTICE FOR ALL CANCELLATIONS
OUR PRACTICE DOES NOT PARTICIPATE WITH ANY INSURANCE PLANS

PLEASE LIST ALL PERSONS LIVING IN THE YOUR HOME INCLUDING ALL CHILDREN IN BIRTH ORDER

NAME	RELATIONSHIP TO CHILD (PATIENT)	BIRTH DATE	BIRTH PLACE	IF ADOPTED, WHEN?	EMPLOYMENT AND/OR SCHOOL/GRADE(PROGRAM)