

# The Therapeutic Center for Children and Families

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Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**NAME OF CHILD:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Child Phone #: \_\_\_\_\_  
(if applicable)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Birth Place: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Religion: \_\_\_\_\_

Custodial Parents: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**NAME OF CHILD'S MOTHER:** \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Birth Place: \_\_\_\_\_  
If applicable, date of arrival in USA: \_\_\_\_\_

If deceased, date & cause of death: \_\_\_\_\_ Religion: \_\_\_\_\_

If different than above, home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

☐ Home#: \_\_\_\_\_ ☐ Work#: \_\_\_\_\_ ☐ Mobile#: \_\_\_\_\_ ☐ Fax#: \_\_\_\_\_

Email Address: \_\_\_\_\_

**If applicable, please include:**

Hours/Days

Occupation: \_\_\_\_\_ of Work: \_\_\_\_\_

Employer: \_\_\_\_\_

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 current marital situation:**

Current marital status: \_\_\_\_\_ # years married: \_\_\_\_\_

Name of spouse: \_\_\_\_\_

Date separated: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date divorced: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date widowed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous marriages? Y N if yes, provide dates: \_\_\_\_\_

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

**NAME OF CHILD'S FATHER:** \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Birth Place: \_\_\_\_\_  
If applicable, date of arrival in USA: \_\_\_\_\_

If deceased, date & cause of death: \_\_\_\_\_ Religion: \_\_\_\_\_

If different than above, home address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

☐ Home#: \_\_\_\_\_ ☐ Work#: \_\_\_\_\_ ☐ Mobile#: \_\_\_\_\_ ☐ Fax#: \_\_\_\_\_

Email Address: \_\_\_\_\_

**If applicable, please include:**

Hours/Days

Occupation: \_\_\_\_\_ of Work: \_\_\_\_\_

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Name of spouse: \_\_\_\_\_

Date separated: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date divorced: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date widowed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous marriages? Y N if yes, provide dates: \_\_\_\_\_

**PLEASE LIST ALL PERSONS LIVING IN THE CHILD'S 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)

(if necessary, please attach another sheet of paper)