Child and Adolescent Intake Form

Patient Name: ___________________________ DOB: / / Gender:

Address: ____

City/State/Zip: ___________________________________ Phone: ( )

Grade:_____ School: ____

Prior Mental Health Treatment? Y / N Psychiatric Hospitalization? Y / N

Pediatrician: ____________________________ Date of Last Physical: / /

Pediatrician's Address: ____

City/State/Zip: ___________________________________

Pediatrician's Phone: ( ) Fax: ( )

Referred by: ____

Reason for referral: ____

Parent/Guardian's Name: ____

Address (if different from patient): ____

City/State/Zip: ___________________________________

Pharmacy Name and Address: ____

City/State/Zip: ___________________________________

Pharmacy's Phone: ( ) Fax: ( )

Please Complete prior to your appointment with Dr. Basheer Lotfi-Fard.