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Therapy Self-Referral - Minors/Guardian

Child's name:_____ **Date of Birth:**_____

Name of guardian/authorized representative:_____

Relationship to child:_____ **Date of Birth:**_____

Address:_____

Phone:_____ **Email:**_____

Contact Preference (texting, calling, email): _____

Reason for Therapy- Please describe why you're looking for therapy for your child and/or family members at this time:

_____

_____

_____

Please check any additional areas of concern you may have with your child or family:

☐ Sadness, isolating	☐ Loss, death of a loved one	☐ Medical	☐ Parenting help
☐ Anxiety	☐ Attention and concentration	☐ School	☐ Separation, divorce, co-parenting
☐ Friends, Social Issues	☐ Anger, outbursts, tantrums	☐ Self-esteem	☐ Communication

Preference for therapy (Virtual, In Person, Both?): _____

How did you hear about us? _____

Today's Date:_____