**LEIGH ANNE MEHLDAU, LCSW**
Licensed Psychotherapist
200 Oak Street, Suite D
Glastonbury, CT 06033
Ph: (860) 558-9595; Fax: (860) 516-4883

# Child Information Form

**Patient Name**: ____________________________________ **Date**: _________________
**Date of Birth:** __________________ **Age:** _______
**Street Address:** __________________________________________________________
**City:** ________________________________**State** ________ **Zip Code:** ____________
**Home Phone**: _____________ **Work:** ______________ **Cell Phone:** ______________

**Parent/Guardian Information**
Mother's Name: _________________________________ Marital Status: ___________
Home Address (if different): ______________________________Phone #:Home ______
Work ______________ Cell ________________ Email: __________________________
Occupation: ______________________________________________________________
Employer: ________________________________________________________________
Work Address: ____________________________________________________________

Father's Name: ______________________________________ Marital Status: _________
Father's Address_________________________________________________________
Phone #: Home ____________ Work ___________ Cell ___________ Email:________
Occupation/Employer: ____________________________________________________
Employer Address: _______________________________________________________

Additional Adults Responsible for Child's Care and Upbringing? YES NO
Who? What is Relationship to the Child? ______________________________________

Other Children in the Home? YES NO
Names & Ages: _______________________________________________________

**Child's Educational History:**
Current School: ____________________________________________ Grade: _________
Address: _________________________________________________________________
Phone: _____________________ Present Teacher(s): __________________________
Current Grades: _________________ Classes Failing: ___________________________
Learning Disabilities: YES NO If yes, in what areas? _________________________
Date of Last PPT and/or evaluations: __________________________________________
_________________________________________________________________

**Who referred your child to this office?** _____________________________________
Why are you seeking therapy services for your child at this time? __________________
_________________________________________________________________________
_________________________________________________________________________
Is there anyone you do not want to know your child attends therapy at this office? Who is this person and for what reason:____________________________________________

**Previous Treatment:** YES NO Reason for therapy: ______________________________
* Provider: __________________________________________ Phone #: ________________
Address: ______________________________________________________________________
* Provider: __________________________________________ Phone #: ________________
Address: ______________________________________________________________________
Alcohol or Substance Abuse Issues? ____________________________________________
Past Partial or In-Patient Hospitalizations: YES NO Why? _________________________
______________________________________________________________________________
Dates: ________________________________________________________________________

**Child's Health/Medical History**

Health/Medical Problems: YES NO Describe: __________________________________
______________________________________________________________________________
Current Medications: YES NO

1. Name: _________________________Dosage: _____________When Started: ____________

2. Name: _________________________Dosage: _____________When Started: ____________

3. Name: _________________________Dosage: _____________When Started: ____________

4. Name: _________________________Dosage: _____________When Started: ____________

**Past Medications for Emotional/Mental Health Purposes?** YES NO
Name (s): _____________________________________________________________________
When did your child take them? ________________________________________________

**Primary Care Physician:** ____________________________________________________
Address: ______________________________________________________________________
______________________________________________________________________________
Phone #: __________________________ Date of Last Physical Exam: ________________

**Additional Medical Providers Your Child Sees Regularly?** YES NO
Name: ____________________________________________ Phone #: _______________
Address: ______________________________________________________________

Name: ____________________________________________ Phone #: _______________
Address: ______________________________________________________________

**Individual Responsible for Scheduling/Canceling Appointments:** ________________

**Emergency Contact:** _________________________________________________________
**Phone #:** _____________________________ **Cell Phone #:** ________________________

**Billing Information**

Insurance Company: ______________________________________________
Subscriber's Name: _______________________________________________
Member #: _________________________ Group #: ______________________
Person Financially Responsible for therapy sessions: ________________________
Street Address: __________________________________________________
City/Town: _____________________ State: ________ Zip Code: ____________
Phone #: H ______________________ Cell Phone: _____________________

***I acknowledge that payment is due at the time of service. I understand that if I fail to attend or cancel a scheduled session less than 24 hours in advance I will be charged a minimum of $75.00. I agree to be financially responsible for my child's missed sessions and sessions cancelled less than 24 hours in advance. I also agree to pay for all services not covered by our health insurance carrier.***

Parent Signature: __________________________________ Date: _________