

**CHILD/ADOLESCENT INFORMATION FORM**  
WESTERN PSYCHOLOGICAL AND COUNSELING SERVICES, P.C.

Date: \_\_\_\_\_

Name: _____ Date of Birth: _____ Gender:    M    F            Age: _____ Social Security/ID # _____	In Care of: _____ Address: _____ City: _____ State: _____ Zip: _____
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**Parent Contact Telephone Numbers**

Please complete relevant information and check boxes of custodial parents or legal guardians.

<input type="checkbox"/> Mother's Name _____	<b>Legal Guardian</b> <input type="checkbox"/>	<b>OK to leave message?</b>
Home Phone (    ) _____		<input type="checkbox"/>
Work Phone (    ) _____ Cell Phone (    ) _____		<input type="checkbox"/>
<input type="checkbox"/> Father's Name _____	<b>Legal Guardian</b> <input type="checkbox"/>	
Home Phone (    ) _____		<input type="checkbox"/>
Work Phone (    ) _____ Cell Phone (    ) _____		<input type="checkbox"/>
<input type="checkbox"/> Step-Mother's Name _____	<b>Legal Guardian</b> <input type="checkbox"/>	
Home Phone (    ) _____		<input type="checkbox"/>
Work Phone (    ) _____ Cell Phone (    ) _____		<input type="checkbox"/>
<input type="checkbox"/> Step-Father's Name _____	<b>Legal Guardian</b> <input type="checkbox"/>	
Home Phone (    ) _____		<input type="checkbox"/>
Work Phone (    ) _____ Cell Phone (    ) _____		<input type="checkbox"/>
<input type="checkbox"/> Legal Guardian (if not listed above) _____	<b>Legal Guardian</b> <input type="checkbox"/>	
Home Phone (    ) _____		<input type="checkbox"/>
Work Phone (    ) _____ Cell Phone (    ) _____		<input type="checkbox"/>

**Emergency Contact Information (other than the person(s) noted above)**

Name \_\_\_\_\_ Home Phone (    ) \_\_\_\_\_  
 Work Phone (    ) \_\_\_\_\_ Cell Phone (    ) \_\_\_\_\_  
 Relationship to child: \_\_\_\_\_ **Legal Guardian**

**Subscriber/Policy Holder's Name** \_\_\_\_\_ **Employer** \_\_\_\_\_  
 Social Security #/ID # \_\_\_\_\_ **OK to leave message?**  
 Home Phone (    ) \_\_\_\_\_ Cell (    ) \_\_\_\_\_   
 Relationship to Child \_\_\_\_\_ **Legal Guardian**

**Primary Care Physician Information**

Current Physician \_\_\_\_\_  
 Physician Address \_\_\_\_\_  
 Physician Phone (    ) \_\_\_\_\_ Physician Fax (    ) \_\_\_\_\_

**School Information**

Current School \_\_\_\_\_ Primary teacher's name \_\_\_\_\_  
 Main contact at school \_\_\_\_\_ School phone number (    ) \_\_\_\_\_

**Employment Information**

Adolescent's work place, if any \_\_\_\_\_  
 Work phone number (    ) \_\_\_\_\_  
 Provider Name: \_\_\_\_\_

Provider notes:
Init: _____