Garden City Marriage & Family Therapy
520 Franklin Avenue, Suite 213, Garden City, NY 11530
(516) 248-0580

Child/Adolescent Form

Child's Name_____

Address _____**City** _____ **Zip**_____

Date of Birth _____ **Age**_____

Referred By _____**May I thank this person for the referral?** ____**yes**____**no**

Parent/s or Guardian/s:

Mother's Name:_____

Address if different from above:_____

Occupation:_____

Home Phone:_____**Cell:**_____**Email**_____

Father's Name:_____

Address if different from above:_____

Occupation:_____

Home Phone:_____**Cell:**_____**Email**_____

Persons living in child's household (other than parents/guardians):

Name	Age	Name	Age

Pediatrician/Family Physician (Name, Address and Telephone Number):

_____
_____
_____
_____

Date of Child's Last physical: _____

Has child been hospitalized? If yes, for what?_____

Is child/adolescent taking any medication, prescribed and/or over-the-counter:

___**yes** ____**no If yes, what?** _____

Previous Counseling: Dates:_____

With whom? _____**For what?**_____

Reason for counseling appointment:_____
_____
_____
_____
_____

I understand that suicidal threats, homicidal threats or child abuse by an adult to a child will be reported.

A 24-hour cancellation notice is appreciated; otherwise 50% fee will be charged.

Do you want to be added to mailing list? ____ **yes** _____**no**

_____ _____

Signature **Date**

(Parent's signature if child is minor)