THERAPY DALLAS

Psychological Services for Children, Adolescents, and Adults
12800 Hillcrest Rd A124, Dallas, TX 75230 • 214-755-6119 • www.therapydallas.com

GENERAL INFORMATION

Date: _____

CHILD/ADOLESCENT:

Name, Age: _____, _____ Birthdate: _____

Address: _____ Phones: (home) _____ msg ok ☐

_____ (child cell?) _____ msg ok ☐

PARENT(S):

Mother, Age: _____, _____ Father, Age: _____, _____

Address (if different from above): Address (if different from above):

_____ _____

_____ _____

Phones: (home) _____ msg ok ☐ Phones: (home) _____ msg ok ☐

(work) _____ msg ok ☐ (work) _____ msg ok ☐

(cell) _____ msg ok ☐ (cell) _____ msg ok ☐

Occupation: _____ Occupation: _____

Highest Grade/Degree: _____ Highest Grade/Degree: _____

Parents' marital status: ☐ married ☐ separated ☐ divorced ☐ never married

If divorced, please provide our office with a complete copy of your finalized divorce decree; additionally, please describe your custody arrangement: _____

SIBLINGS:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Please list any other people living in the home(s): _____

SCHOOL:

Name: _____ Grade: _____ Phone: _____

Primary Teacher(s): _____ School Counselor: _____

PEDIATRICIAN:

Name: _____ Phone: _____

EMERGENCY CONTACT(S):

Name, relationship to child: _____ Phone: _____

Name, relationship to child: _____ Phone: _____

REFERRAL SOURCE:

Referred by: _____ Phone: _____

Consent to acknowledge the referral? ☐ Yes ☐ No