



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? <input type="checkbox"/> yes <input type="checkbox"/> 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
(Parent's signature if child is minor)

Date

