



33493 West 14 Mile Road, Suite 130  
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(248)851-KIDS (5437)  
ChildAndFamilySolutionsCenter.com

### CLIENT INFORMATION

Today's date	_____		
Client's name	_____	Date of birth	_____
Age	_____	Phone # (cell)	_____
Home address	_____		
City	_____	State	_____ Zip _____
Mother's name	_____	Father's name	_____
Employer	_____	Employer	_____
Phone # (home)	_____	Phone # (home)	_____
Ok to leave a message? Yes No		Ok to leave a message? Yes No	
Phone # (work)	_____	Phone # (work)	_____
Phone # (cell)	_____	Phone # (cell)	_____
E-mail address	_____	E-mail address	_____
Parent's marital status	_____	Step-mother	_____
Date married	_____	Step-father	_____
Date divorced (if applicable)	_____		
Current custody arrangement	_____		

Referred to practice by \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

### School information

School	_____	School district	_____
Current grade	_____	Teacher/counselor	_____
School phone #	_____		

**School information** (continued)

Please list previous schools

<i>Name</i>	<i>Grades</i>	<i>Years attended</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever been evaluated for special education or a Section 504 plan? \_\_\_\_\_

If yes, does the child have an IEP? \_\_\_\_\_ Date of most recent review? \_\_\_\_\_

Has your child ever been retained? \_\_\_\_\_

**Health information**

Pediatrician/family physician \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone # \_\_\_\_\_

May we contact the physician to provide a consultation? \_\_\_\_\_  
(If yes, a release of information will be signed at the intake.)

**Family**

List of (full/half/step) siblings in order of age

<i>Name</i>	<i>Relationship</i>	<i>Age</i>	<i>History of illness (physical/mental)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other people living in the home: \_\_\_\_\_

Primary / Secondary language spoken in the home: \_\_\_\_\_

Non-residential adults involved with your child on a regular basis: \_\_\_\_\_

## Prior Psychological Services

Has the child/family received prior psychological services? \_\_\_\_\_

If yes, please list previous therapists/psychiatrists, dates of services, and reason for seeking services:

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