The Personal Wellness Center

6508 Deer Pointe Dr. Ste. 4C, Salisbury, Maryland 21804
Telephone: 410-742-6016

PERSONAL INFORMATION Child/Adolescent

****Upon arrival please submit insurance card and driver's license (to be copied), referrals and any other applicable paperwork. Thank you****

Today's date: ______________________________

Child's Name: ________________ Middle ____________ Last: ______________________

Birthdate: ________________ Age: ______ Sex: Choose one...

Child's home address: ____

____
City State Zip Code

Parent/Legal Guardian Name: ____

Legal Guardian completing this form:
Mother ◯ Father ◯ Stepmother ◯ Stepfather ◯ Adoptive parent ◯ Caregiver (foster parent, grandparent)

E-mail address: ____

****If you prefer not to be included in our monthly newsletter, please let us know****

Guardian's Phone Number: ________________ ________________ ________________
Home Cell Office

****If you prefer not to be contacted at any of the numbers you listed above, please indicate****

Parent's relationship status: Sep ☐ M ☐ D ☐ W ☐ Single ☐ Not married but living together ☐

Person to contact in case of emergency: ____

Phone #: ________________________ Relationship ________________________

Name, address, phone # for person responsible for payment: ____________________________

Referred to **The Personal Wellness Center** by ____

Name, of child's primary care physician ____

Has child ever had counseling or therapy prior to today? Choose one...

Previous diagnosis: ____

Revised 06/2020

History of mental health illness in the family Choose one...

Known diagnoses: ____________________

Child's health

Current health concerns: ____________________

Developmental concerns: ____________________

Current prescribed medications: ____________________

History of head injury: ____________________

Allergies: ____________________

Education

Name of school currently attending ____________________ Grade: __________

Has your child ever been diagnosed with ADHD or a learning disability? Choose one...

Has your child ever received special education services? Choose one...

Any recent changes in our child's school grades? Choose one...

Has your child ever been held back in school? Choose one...

Has your child ever been evaluated? Choose one...

Has your child ever been suspended or expelled from school? Choose one...

Any other concerns related to your child's school? ____________________

Drug and alcohol history

Does your child currently use alcohol or recreational drugs? Choose one...

In the past, has your child used alcohol or recreational drugs? Choose one...

Has your child received treatment for alcohol or drugs? Choose one...

Has anyone in your family had a problem with drugs or alcohol? Choose one...

Safety Concerns

Has your child ever had thoughts of harming or killing himself/herself? Choose one... When: __________

Has your child ever attempted to commit suicide? Choose one... How: __________

Has your child ever had thoughts of hurting others? Choose one... When: __________

Has your child ever attempted to hurt someone else? Choose one... How: __________

Legal Concerns:

Has your child ever been arrested? Choose one... When: ____________________

Current or past legal problems? Choose one... Explain: ____________________

Is your child currently on probation? Choose one...

Is child a transition youth consumer? Choose one...

Primary language: ☐ English ☐ Spanish ☐ Other Specify: ______________________________

Living situation: ☐ Private Home ☐ Foster Home ☐ Residential Care ☐ Institutional Setting
☐ Homeless ☐ Other Specify: ______________________________

Disability Status: ☐ Hearing problems ☐ Vision Problems ☐ Difficulty Walking ☐ Difficulty Dressing/Bathing
☐ Difficulty doing errands alone ☐ Other Specify: ______________________

Spanish/Latino origin? Choose one... Race: ☐ White ☐ African American ☐ American Indian or Alaskan Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Multi-Racial

Primary Insurance Information

Insurance carrier: ______________________________ Policy # ______________________
Insured's Name: ____
Person who is primary on insurance
Insured's Address: ____
Insured's Birthdate ______________ Insured's Employer ______________________________

Secondary Insurance Information -if applicable
Insurance carrier: ______________________________ Policy # ______________________
Insured's Name: ____
Person who is primary on insurance
Insured's Address: ____
Insured's Birthdate ______________ Insured's Employer ______________________________

What specific goals would you like your child to work on in therapy?

1. ______________________________
2. ______________________________
3. ______________________________