# 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: M F

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? Y N

Previous diagnosis: _____

History of mental health illness in the family Y N

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? Y N

Has your child ever received special education services? Y N

Any recent changes in our child's school grades? Y N

Has your child ever been held back in school? Y N

Has your child ever been evaluated? Y N

Has your child ever been suspended or expelled from school? Y N

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

**Drug and alcohol history**

Does your child currently use alcohol or recreational drugs? Y N

In the past, has your child used alcohol or recreational drugs? Y N

Has your child received treatment for alcohol or drugs? Y N

Has anyone in your family had a problem with drugs or alcohol? Y N

**Safety Concerns**

Has your child ever had thoughts of harming or killing himself/herself? Y N When: _____

Has your child ever attempted to commit suicide? Y N How: _____

Has your child ever had thoughts of hurting others? Y N When: _____

Has your child ever attempted to hurt someone else? Y N How: _____

**Legal Concerns:**

Has your child ever been arrested? Y N When: _____

Current or past legal problems? Y N Explain: _____

Is your child currently on probation? Y N

Is child a transition youth consumer? Y N

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 Y N Race: __White __African American __American Indian or Alaskan Native
__Asia __Native Hawaiian or Other Pacific Islander

**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. _____