Child Demographic Information

Please complete Front and Back and Return to the Receptionist.

Client Full Name							**Preferred Name**		
Date of Birth			**Age**			**Social Security #**			
Gender		**Sex**		**Marital Status**			**Primary Language**		
Race			**Ethnicity**						
Home Address									
City			**State**			**Zip**			
Main Phone		**Type**		**Other Phone**			**Type**		
Other Phone		**Type**		**Other Phone**			**Type**		
E-mail Address									

Guardian #1 Full Name							**Preferred Name**		
Date of Birth			**Age**			**Social Security #**			
Gender		**Marital Status**			**Primary Language**				
Race			**Ethnicity**						
Home Address									
City			**State**			**Zip**			
Main Phone		**Type**		**Other Phone**			**Type**		
Other Phone		**Type**		**Other Phone**			**Type**		
Email Address						**Relationship to Client**			
Is this person a medical decision maker for the child?	☐ **Yes** ☐ **No**		**Custody Status**						

Guardian #2 Full Name							**Preferred Name**		
Date of Birth			**Age**			**Social Security #**			
Gender		**Marital Status**			**Primary Language**				
Race			**Ethnicity**						
Home Address									
City			**State**			**Zip**			
Main Phone		**Type**		**Other Phone**			**Type**		
Other Phone		**Type**		**Other Phone**			**Type**		
Email Address						**Relationship to Client**			
Is this person a medical decision maker for the child?	☐ **Yes** ☐ **No**		**Custody Status**						

Client Name: _____ **Date of Birth:** _____

Guardian Name: _____

School					**Grade**		
Emergency Contact:					**Relationship to Client**		
Main Phone		**Type**		**Other Phone**		**Type**	
Financial Guarantor		**Guarantor's Date of Birth**			**Relationship to Client**		
Guarantor's Home Address							
City		**State**			**Zip**		
Main Phone		**Type**		**Other Phone**		**Type**	
Who Referred You/How did you hear about us?	☐ **Doctor** _____ ☐ **Attorney** _____ ☐ **Social Worker/DCBS** _____ ☐ **School** _____ ☐ **Judge** _____ ☐ **Friend or Family** _____ ☐ **Insurance Company** _____ ☐ **Internet Search** _____ ☐ **Other** _____						
Primary Care Doctor					**Are you interested in School Based Services?**	☐ **Yes** ☐ **No**	
Are you working with other agencies/services and would like us to be able to speak with them?	☐ **Doctor(s)** _____ ☐ **Psychiatrist** _____ ☐ **School** _____ ☐ **Social Worker/DCBS** _____ ☐ **Court System** _____ ☐ **KAPS** _____ ☐ **Attorney** _____ ☐ **Other(S)** _____						
Appointment Reminder	**Would you like us to provide appointment reminders?** ☐ **Yes** ☐ **No** **If yes, how (choose one)?** ☐ **Call** _____ ☐ **Email** _____						

Additional Comments/Information:

Client Name: _____

Date of Birth: _____

Guardian's Name: _____

*** Please list anyone you would like to be able to have contact with our office about your child's appointments…make sure to include any of the following:*

- Anyone you want to allow to call and get information about and/or schedule your appointments
- Anyone with whom you may share custody of your child
- Anyone who may assist with bringing your child to appointments or picking them up from appointments
- Your child's social worker, Case worker, Court Designated Worker (CDW), and/or anyone else working with your family with whom you'd like us to contact

Contact #1				**Relationship to Client**			
Main Phone		**Type**		**Other Phone**		**Type**	
E-mail							
Contact #2				**Relationship to Client**			
Main Phone		**Type**		**Other Phone**		**Type**	
E-mail							
Contact #3				**Relationship to Client**			
Main Phone		**Type**		**Other Phone**		**Type**	
E-mail							
Contact #4				**Relationship to Client**			
Main Phone		**Type**		**Other Phone**		**Type**	
E-mail							
Contact #5				**Relationship to Client**			
Main Phone		**Type**		**Other Phone**		**Type**	
E-mail							

Additional Information/Notes: