Cunningham Counseling
1 Walpole Street, Suite 7
Norwood, MA 02062

Child Information Sheet

Child's Name: _____ DOB: _____

Ethnicity: _____ Gender: _____

Address: _____

Phone Numbers: _____ Email: _____

_____ Messages via phone, email & text: Y N

Parent/Guardian:_____ Relationship to child: _____

Parent/Guardian:_____ Relationship to child: _____

Custody (Please note both **physical** and **legal** custody arrangements):

_____

Emergency Contacts: Name: _____ Name: _____

Phone: _____ Phone: _____

Relationship: _____ Relationship:_____

Reason for seeking counseling at this time: _____

_____

How did you hear about us?: _____

Has client seen a therapist in the last year? Y___ N___ If yes, how many sessions? _____

List any medication that your child is currently prescribed: _____

_____

Allergies: _____ Health Concerns: _____

Primary Care Physician: _____ Phone: _____

Psychiatrist (If Applicable): _____ Phone: _____

Insurance Information:

Insurance Provider: _____ Policy Number: _____

Policy Holder: _____ Relationship to subscriber:_____

Policy Holder DOB:_____ Co-pay Amount:_____ Deductible Met: Y___ N___

Allotted # of Sessions:_____

_____

Print Name Signature Date

Office Use:

Dx _____ Date_____ Signature _____