

**Minor Information Form**  
(Please print)

Today's Date: \_\_\_\_\_

Minor's Name \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Minor's Name \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Minor's Name \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Minor's Name \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Minor's Name \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Name of Guardian(s) \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City Zip Code

Home Ph#: \_\_\_\_\_ Work Ph#: \_\_\_\_\_ Other: \_\_\_\_\_

Marital Status: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( ) Live-In ( )

Employed By: \_\_\_\_\_  
Name of Company Address Phone

Referred By: \_\_\_\_\_  
Source/Name

Emergency Contact: \_\_\_\_\_  
Name Address Phone Relationship

Insurance: \_\_\_\_\_  
Name Policy # Insured's Name

Insurance Billing Address City State Provider Information Telephone #

Has your child/children ever seen a mental health professional before? ( ) Yes ( ) No

If yes, please indicate circumstances:

Who	When (dates)	For What Problem(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Birthplace \_\_\_\_\_

Was your child breast fed and if so, for how long? \_\_\_\_\_

Any change of residences or schools? ( ) Yes ( ) No

If yes, estimate the number of moves and school changes made up to now \_\_\_\_\_

\_\_\_\_\_

Please describe the circumstances \_\_\_\_\_

If parents are not together, please explain the circumstances for separation \_\_\_\_\_

\_\_\_\_\_

Please mark where indicated for the household: ( ) Substance Abuse, ( ) Separation, ( ) Multiple Separations, ( ) Divorce, ( ) Domestic violence, ( ) Legal Problems

Parent's Occupation \_\_\_\_\_

List any siblings (brothers/sisters) and their ages

Sibling	Age	Sibling	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please explain any significant medical history or experiences \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any major traumas, surgeries, serious accidents, or diseases \_\_\_\_\_

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Please list any challenges or disabilities that your child has \_\_\_\_\_

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Either parent smoke? \_\_\_\_\_ How much? \_\_\_\_\_ Inside the home? \_\_\_\_\_

Either parent drink alcoholic beverages? \_\_\_\_\_ Please indicate how much and how frequently

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Is there anything else you would like to say about your child, children or family? \_\_\_\_\_

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