

Child / Adolescent Intake

Completed by parent or legal guardian. Return via the secure patient portal or bring to your visit.

Child / Adolescent Information

Child's Full Legal Name

Preferred Name

Date of Birth

School / Grade

Primary Care Provider

Parent / Legal Guardian

Guardian Name

Relationship to Child

Phone (best contact)

Email

Street Address

City / State / ZIP

Legal Custody Status

Insurance (Child)

Insurance Carrier

Member ID

**Group #
Policy Holder Name &
DOB**

Reason For Visit

Current Medications

Developmental / Behavioral History

Patient/Guardian Signature: _____ Date: _____