KENNETH A. DE LUCA, Ph.D. & Associates, Inc.

CHILD AND ADOLESCENT REQUEST FOR SERVICES

****The following is vital information in helping us to help you. Thank you!****

DATE: _____

CHILD'S NAME: _____
(LAST) (FIRST) (MI)

BIRTHDATE: _____ AGE: _____ SEX: _____ S.S.NO: _____

ADDRESS: _____
(STREET) (CITY) (ZIPCODE)

MOTHER'S NAME: _____ AGE: _____
(LAST) (FIRST) (MI)

BIRTHDATE: _____ S.S. NO: _____ PHONE: _____

ADDRESS (if different from child): _____
(STREET) (CITY) (ZIP CODE)

EDUCATION: _____ OCCUPATION: _____

EMPLOYER: _____ BUSINESS PHONE: _____

BEST NUMBER TO REACH YOU AT 1. _____ 2. _____ 3. _____

FATHER'S NAME: _____ AGE: _____
(LAST) (FIRST) (MI)

BIRTHDATE: _____ S.S. NO: _____ PHONE: _____

ADDRESS (if different from child): _____
(STREET) (CITY) (ZIP CODE)

EDUCATION: _____ OCCUPATION: _____

EMPLOYER: _____ BUSINESS PHONE: _____

BEST NUMBER TO REACH YOU AT 1. _____ 2. _____ 3. _____

Please describe the reason for your child's visit: _____

_____

_____

List all immediate family and significant relationships not listed above:

Name	Relationship	Age & DOB	Health Issues (specify)

Parent/Guardian Marital Status (as applicable):

Parent's Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If child's parents are married to each other, Years married: _____ Child's age when divorce occurred: _____

If child's parents are separated or divorced, Years separated: _____ Years divorced: _____

Who does child currently live with: _____

Who is the child's legal guardian? _____

Describe the custody agreement: _____

Location of noncustodial parent and extent of contact/visitation: _____

Additional Information: _____

_____

School: _____ City: _____ Phone: _____
Grade: _____ Teacher(s): _____
Placement :☐ Mainstream ☐ Special education (IEP), type: _____
☐ Gifted/Honors ☐ Retention, what grade? ____ ☐ Other services: _____
Describe strength and problem areas: _____

Please list any stressors that your child or family has experienced recently (i.e. job change or loss, family illness or injury, accidents, death, moves, violence, crime victimization, etc.): _____

Please describe any PAST or PENDING legal matters including visitation/custody proceedings:

Please list any mental health services or chemical dependency; including counseling, your child or a family member has previously received:

Name	Provider/Agency	Dates	Reason	Outpatient and/or Inpatient

CURRENT MEDICATIONS

Name	Dosage	Purpose	Prescribing Doctor	Side Effects?

- **ALLERGIES TO MEDICATIONS:** _____
- **EMERGENCY CONTACT:** _____
  (Name) (phone) (relationship)
- **REFERRAL SOURCE or why, or how, did you select us:**

- I understand that my records are protected by laws governing confidentiality and cannot be disclosed without my written consent. I understand that I can revoke my consent at any time except when disclosure has already occurred. This consent will automatically expire twelve months from the date signed.

- Please check one: ___Please release any applicable information to our primary care/referring physician.
  ___Do not release any information to our physician. ___We do not have a primary care physician.

- **Primary Care Physician's Name, Address & Telephone Number:**

I agree and consent to the participation of my child in mental health services offered and provided by Kenneth A. De Luca, Ph.D. & Associates, Inc. I have reviewed a copy of the Ohio Notice Form: Notice of Psychologist, Counselor, and Social Worker Policies and Practices to Protect the Privacy of Your Health Information for the group of Kenneth A. De Luca, Ph.D. & Associates, Inc.

- **SIGNATURE of custodial parent:** _____ Date: _____
  CLINICIAN'S SIGNATURE: _____ Date: _____