Behavioral Healthcare of Fredericksburg

312 Progress Street, Suite 200, Fredericksburg, VA 22401

CHILD INTAKE

Office use only

Date: ______________________ Referred by: ________________________________ Dx:

Child's Name: __________________________________ SS #_____________________ Male Female

Address: ____ (Parent Home/Cell) Phone:( )______________________

City State & Zip ____ Date of Birth________________________

Parent E-Mail: ____

Name, Age and Relationship of Others Living with patient: ____

____

I am here because: ____

____

Have you seen any other Mental Health Professional within the past year? *Yes* *No*

Name of Practitioner:____

Patient Insurance Information

Insurance Company ____________________________________

ID # ____________________________________

Insured's Address (if same as above, write same) ____________________________________

____

Insured's Birth date _______________________ Male Female

Patient's Relationship *Self* *Spouse* *Child* *Other*

Employer ____________________________________

Authorization to Treat Minor

I, ____ am the parent and/or Legal Guardian of this

Child. I authorize (Provider Name) ____ to evaluate and perform

appropriate psychological assessment and treatment procedures.

Signature: ____ Date: ______________________

Parent or Responsible Party