**CHILD CLIENT INFORMATION**

*Please Print Clearly*
THIS SHEET MUST BE FILLED IN COMPLETELY

Date:________________

Child's First Name:___________________Last Name:______________________________MI____

Address:______________________________________________________City:________________

State:________________ Zip:__________________________________________________________

Telephone (Home):__________________ (Work):____________________(Cell):________________

Permission to leave a message at home? Yes___________ No ___________________________

Email address:___________________________________________________________________

Birthdate: ________/________/_______Age: _______________Gender: M___________F_____

Mother's First Name:_______________________Last Name:________________________________

Place of Employment: ______________________Occupation:______________________________

Years of Schooling: ____Work Phone:________Permission to call you at work? Y______ N_____

Father's First Name:________________________Last Name:________________________________

Place of Employment: ______________________Occupation:______________________________

Years of Schooling: ____Work Phone:________Permission to call you at work? Y______ N_____

Child's legal guardian (if not parents):_________________________________________________

Legal Guardian's Address:___________________________________________________________

Child lives with: Mother & Father _____ Mother ____ Father _____ Step-Parent _____

Other _______________

If parents are divorced, is there joint LEGAL custody? Y____ N____

Please list all others who live in the household and their ages:

Name Age Name Age

_________________________________________________________________________________

_________________________________________________________________________________

LINDEMAN & ASSOCIATES Psychological Services

---

Person Responsible for Payment:______________________________________________

Signature of Person Responsible for Payment:__________________________________

*(Must be signed for services to begin)*

---

**Emergency Information**

In case of emergency, contact:

Name (1): ____________________________ Relationship:________ Phone: ____________

Address:________________________City:______________State:____Zip Code:_________

Name (2): ____________________________ Relationship:________ Phone: ____________

Address:________________________City:______________State:___Zip Code:__________

---

Physician:_____________________________________________Phone:______________

Address:________________________ City:__________State:______Zip Code:___________

---

Psychiatrist:_____________________________________________ Phone:_____________

Address:________________________City:_________ State:________Zip Code:___________

---

Other Treating Physicians:____________________________Phone:____________________

________________________________________________Phone:____________________

Current Medications:_____________________________________________________

Allergies:_____________________________________________________________

---

**PRIMARY INSURANCE:**

Patient relationship to insured: Self_________Spouse_______Child________Other________

Insured's Name:________________________Employer:_____________________________

Insured's Address:_________________________________________________________

Insurance Co/Plan:_________________________________________________________

Insured's DOB:________________________Insured's ID #:__________________________

Insured's SSN:_________________________Insured's Group/Policy #:_________________

**SECONDARY INSURANCE:**

Patient relationship to insured: Self_________Spouse_______Child________Other________

Insured's Name:______________________Employer:_________________________________

LINDEMAN
& ASSOCIATES
Psychological Services

Insured's Address: ________________________________________________________________

Insurance Co/Plan:_______________________________________________________________

Insured's DOB:___________________________ Insured's ID #:___________________________

Insured's SSN:___________________________ Insured's Group/Policy #:___________________

---

**** Please note: If you do not provide our office with accurate insurance information at the time of service, payment for these services will be your responsibility. Please make sure to list ALL accurate insurance information. My signature below indicates that I understand and agree with all of these statements. I certify that all information is true, accurate and complete. I agree to be personally responsible for all charges not covered by my insurance.**

---

Signature of Client Or Legal Guardian:__________________________________ Date:_________

Signature of Therapist:________________________________________________ Date:_________

Signature of Psychologist:_____________________________________________ Date:_________