LINDEMAN & ASSOCIATES
Psychological Services

SCREENING INFORMATION (CHILD)

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):_____

Is it OK to leave a message at home? Yes_____ No _____

Email address:_____

Birthdate: _____/_____/_____Age: _____Gender: F____M_____

Mother's First Name:_____Last Name:_____

Place of Employment: _____Occupation:_____

Years of Schooling: ____Work Phone:_____Is it OK to call you at work? Y_____ N____

Father's First Name:_____Last Name:_____

Place of Employment: _____Occupation:_____

Years of Schooling: ____Work Phone:_____Is it OK 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:_____SSN:_____

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:_____

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 Psychologist/Therapist:_____

Date:_____