



610 W. Peace St.
Raleigh, NC 27605
(919) 755-0545

Date _____

Referral source if applicable: _____

Patient's Name _____

Age: _____ Date of Birth: _____

School, Grade level, GPA: _____

Parent(s) Name(s) Including Stepparents: _____

Phone numbers:

Mother and/or Stepmother home, work, cell: _____

Father and/or Stepfather home, work, cell: _____

Patient home, work, cell: _____

Email Parents: _____

Email Patient if applicable: _____

Parents' Employment: _____

Responsible Party & Current Mailing Address:

City

Zip

Sibling names and ages (including half siblings and stepsiblings):

Please briefly describe the difficulty that brought you to seek our services:

Current/Previous Mental Health Diagnosis:

Can you list goals and/or expectations of your child's therapy?(continue on back if needed)



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Current Medications, Dosages, and who prescribed:

Primary Care Physician & Phone number:

Previous Psychiatrists or therapists:

Previous Hospitalizations (Hospital, Date, Reason for Admission):