*Capital Psychological Services, LLC*

**CHILD INFORMATION**

Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City & State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT INFORMATION**

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from child):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*By providing an email addresses I am giving Cendrine Robinson, PhD and Capital Psychological Services (CPS), LLC permission to make contact via email. I understand that email cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. I understand that Cendrine Robinson, Ph.D. and CPS, LLC do not accept liability for any errors that may arise as a result of email transmission.

Parent’s Relationship Status (please circle):

Single Significant Relationship Married/Partnered

Separated Divorced Widowed

Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you learn about my practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do I have permission to contact this referral source (please circle)? Yes No

If yes, please provide contact information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact for child (not a parent) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give consent for my child to receive assessment/psychotherapy *(if parents are divorced with joint custody – both parents need to consent and sign)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian Date