Center for Psychological Assessment & Consultation, PC

510 Princess Anne St, Suite 102
Fredericksburg, VA 22401
Phone: (540) 698-0003

Patient Information Form (Adolescent/Child)

Patient Information:
Last Name:_____ Middle:_____ First:_____
Date of Birth:_____ Gender:_____ Parent/
Guardian(s):_____
Parent(s)/Guardian(s) are: Married:____ Single:____Separated:___ Divorced:___
Custody Arrangement (sole/joint):_____
Do all legal guardians agree to this assessment? __ Yes; __ No (if no, please explain)

Contact Information:
(Note: If the child has multiple guardians who live separately, please list addresses and contact information for both/all)

Primary Address:_____
City:_____ State:_____ Zip Code:_____
Secondary Address:_____
City:_____ State:_____ Zip Code:_____
Cell Phone:_____ Ok to leave voicemail? yes ____ no____
Home Phone:_____ Ok to leave voicemail? yes ____ no____
Work Phone:_____ Ok to leave voicemail? yes ____ no____
Emergency Contact:_____ Relationship:_____ Phone:_____
(your provider may attempt to contact this person in case of emergency)

Other Information:
School Name:_____ Grade:_____
Teacher(s):_____
Primary Care/Pediatrician Name:_____
Practice Name:_____
Current Medications: _____
_____

Has the child received testing services in the past? ___No ___ Yes (If yes, please provides dates and copies of psychological or educational testing reports if possible)

Is the child currently in therapy? ___No; ___ Yes (name of therapist:_____)