CHILD INTAKE QUESTIONNAIRE

Identifying Information

Child's Name:		D.O.B.:		Age:	
School:		Teacher:		Grade:	
How did you hear about our clinic?					
Medicare No.:		IRN:		Doctor:	

Guardian's Information

Guardian Name(s):			
Child's Home Address:			
Home Phone:		Mobile:	
Can we contact you at home?		Can we leave a message?	
Special Instructions:			
Medicare No.:		IRN:	
Is a third party paying for this service?			

Emergency Contact Information

Emergency Contact Name:		Relationship to Child:	
Emergency Contact Address:			
Home Phone:		Mobile:	

Mother's Information

Name:		D.O.B.:	
Address:			
Home Phone:		Mobile:	
Occupation:		Marital Status:	

Father's Information

Name:		D.O.B.:	
Address:			
Home Phone:		Mobile:	
Occupation:		Marital Status:	

Siblings

Name	Age	Do they live in the same house?

Reason for Seeking Treatment

Thank you for your time and cooperation.