Address Phone: Email: Preferred method of contact for appointment reminders: Text Phone Email Insurance Information: INSURANCE CARRIER: POLICY HOLDER NAME:	Chile	d/Teen's Name:Date of Birth		
If the individual listed as parent is not biological parent, do you have proof of guardianship or POA? NO VES N Address	Soci	al Security Number		
Address	Pare	ent(s) Name(s)		
Phone:	If th	e individual listed as parent is not biological parent, do you have proof of guardianship or POA? NO	YES	N/A
Preferred method of contact for appointment reminders: Text Phone Email Insurance Information: INSURANCE CARRIER: POLICY HOLDER NAME:	Add	lress		
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(List)	6.	School? Is child/teen on an IEP?	NO YES	
	7.	Support groups: NONE or		
8 # of HOUSEHOLD MEMBERS Annual Income \$		(List)		
- 7 οι 11000ΕΠΟΕΡ ΠΕΠΡΕΙΙΟ / ΜΠΙΔΙΙΙΠΟΟΙΠΟ Ψ	8.	# of HOUSEHOLD MEMBERS Annual Income \$		
9. Does child/teen have a family doctor or primary care provider?	9.	Does child/teen have a family doctor or primary care provider?		
YES(who)		YES(who)		

10.	Is child/teen currently taking medications? NO YES (list below) Medications
11.	— Check any HEALTH ISSUES that apply to child/teen - Diabetes □ cardiovascular disease □ High Blood Pressure □ High Cholesterol □ Cancer □ Smoking □ Obesity □ Asthma
12.	Are there any issues with speech, hearing or vision? (explain)
14.	Did mother receive prenatal care during pregnancy? No Yes Were there any complications during labor or delivery? NO Yes (explain) Was there any prenatal exposure to substances including prescribed medications? NO Yes (explain)
16.	Did child/teen meet all developmental milestones such as talking? No (explain) Yes
17.	Has child/teen ever been to counseling before? No Yes (where, when and diagnosis if other than CMHC)

Additional comments: