Lansing Psychological Associates, P.C.
234 Michigan Avenue
East Lansing, MI 48823
(517) 337-6545 FAX (517) 337-3010

CHILD PERSONAL DATA SHEET

(Birth through Age 17)

Please complete the following. All material is confidential and will not be released except on your written request.

Child's Name: ______________________________ Date: ______________

Address: ____
Street Apt. No.

____
City State ZIP

Home Phone: Mother __________ Work Phone: Mother __________

Father __________ Father __________

Cell Phone: Mother __________ Father __________

Age: _____ Gender: ______ Birth Date: __________ Birth Place: ______________

Ethnicity Origin (or race): ______________________

Grade: ________ School: ______________________________

Mother's Name: ______________ Mother's Occupation: ______________

Mother's Address: ____________________________________
Street City State ZIP

Father's Name: ______________ Father's Occupation: ______________

Father's Address: ____________________________________
Street City State ZIP

Names and birth dates of child's siblings and/or stepsiblings: ______________________

____

Names, ages, and relationship of child to other people living in the home: ______________

____

Who referred you here? ______________________________

Has the child previously been seen at this clinic? _______ If yes, approx. how long ago? ______________

Has the child received psychological treatment in another location? ________

If yes, when and with whom? ______________________________

Please state briefly the questions or problems which prompted you to bring your child to the clinic at this time:

____

____

Name and phone # of family physician: ____

Please list all medications currently being taking:

Medication	Dosage and How Often	What Reason	How Long
________________________	_________________	_______________________	________
________________________	_________________	_______________________	________
________________________	_________________	_______________________	________
________________________	_________________	_______________________	________

Date of last comprehensive physical examination: ____________

Findings within normal limits? Yes ___ No ___ If no, specify problems/diagnoses: ______________________________

____

Please list any disabilities your child has: ____

Please list any benefits (treatment and/or monetary) being received because of child's disabilities:

____

What allergies or sensitivities does child have? ____

Do you have insurance that will pay for psychological services? ______

Name of insurance company: ____

Policyholder's name: ______________________________ Group Policy No. ______________________________

Child's relationship to policyholder: ___________________________ Policyholder's DOB: ________________________

Contract number or policyholder's social security number: ____

Policyholder's employer: ____

Service code or coverage plan number: ____

Please list any other health benefits or secondary insurances you may have: ____

____

In case of an emergency, please give name and address of a person you would like notified:

Name: ____ Relationship: __________________________

Address: ____ Phone No.: ____________________________

Street Apt. No.

____

City State ZIP

Do you have an advanced directive? Yes ___ No ___

Comment: ____

Please feel free to ask the receptionist or your therapist any questions you may have concerning any of the information requested.

Revised: 11/10/17