Paul Gillane LMFT
Personal Information
(Minor)

Child's Name _____ Date _____

Street _____ City_____ Zip_____

Child's cell phone _____-_____-_____ Email address: _____

Mother's Work Phone/Cell _____-_____-_____ Father's Work Phone/Cell _____-_____-_____

Age ____ Birthdate _____ Sex ____ With whom does child live?
_____

If parents divorced, who has custody? _____ Sex/Age of siblings _____

Current grade in school _____ Name/Address of school _____

Mother's occupation _____ Father's occupation _____

Net monthly income _____

Please check the problem areas where you feel you need help:

☐ school behavior ☐ moodiness / depression ☐ peer relationships
☐ academic performance ☐ family / sibling relationships ☐ fears
☐ drug / alcohol abuse ☐ disobedience at home ☐
other_____

Previous psychological counseling? ___ Child ___ Sibling(s) ___ Mother ___ Father

Therapist _____ Where _____ Duration _____

List child's medical problems
_____

Pediatrician's name _____ Phone _____

List medications child takes regularly _____

How did you hear about us? _____

May we say who we are if we phone your home? ☐ Y / ☐ N … if we phone your work? ☐ Y / ☐ N