

**Personal Data Form**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Phone Numbers:	<u>Okay to call?</u>	<u>Okay to leave message?</u>
Home: _____	Yes / No	Yes / No
Work: _____	Yes / No	Yes / No
Cell: _____	Yes / No	Yes / No

Special Instructions for leaving messages (if any): \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Child's Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Parent/Guardian Relationship Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced  
(check applicable) \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Domestic Partner

Child's School: \_\_\_\_\_

Grade: \_\_\_\_\_

Primary Care Physician and Phone Number: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Please describe the reason(s) for your child seeking treatment at this time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

At the end of therapy, do we have your permission for the Director, Dr. Ziegler, to contact you to ask you about your experience at the HVCCT? Yes \_\_\_\_\_ No \_\_\_\_\_