BACKGROUND INFORMATION

PLEASE PRINT AND GIVE COMPLETE ADDRESSES, INCLUDING ZIP CODES & TELEPHONE NUMBERS

Name, Address & Phone: Doctors, Hospitals, Clinics, Psychiatrists, Psychologists, etc.	Name of Person(s) who received treatment	Approximate Date(s) seen
Phone: ( )		
Phone: ( )		
Phone: ( )		
Phone: ( )		
Phone: ( )		

If there is any other person in the home who has custodial responsibility for the minor child(ren) or any person who may be a paternal figure to the child, please state name(s) of person(s) and address(es).

_____ _____

If party remarried, please state name and address of spouse.

NOTE: **IF NO PSYCHIATRIST OR MEDICAL HISTORY, PLEASE STATE "NONE."**

Name, Address & Phone: Schools attended by children	Name of Person(s) attending	Approximate Date(s) of attendance and grade level
Phone: ( )		Name of Principal or Contact Person:
Phone: ( )		Name of Principal or Contact Person:
Phone: ( )		Name of Principal or Contact Person:
Phone: ( )		Name of Principal or Contact Person:
Phone: ( )		Name of Principal or Contact Person:

NOTE: **IF NO SCHOOLS, PLEASE STATE "NONE." PLEASE LIST ALL SCHOOLS PRESENTLY AND FORMERLY ATTENDED BY ALL CHILDREN, GIVING FULL CORRECT NAME AND ADDRESS.**

PLEASE RETURN IMMEDIATELY. INFORMATION NEEDED PRIOR TO APPOINTMENT.