Name: _____Date:_____

KN Mental Health Services LLC

Child Registration Form

Form Completed by:_____

Child's Name: _____ Sex: M F Age:_____

Date of Birth: _____ Ethnicity: _____

Adopted: Yes____ No ____ Current or previous foster care: Yes___ No___

Parent or Guardian's Name: _____

Address:_____

Home Phone: _____ Cell phone:_____

Email: _____

Preferred method of contact: (Circle one) Phone Text Email Any

Parent(s) are (circle one) single/ married/ separated/ divorced/ remarried/ widowed/ live together

If divorced, what are the custody arrangements?

(Please bring a copy of custody of agreement for the chart)

Please provide other parent's name and contact information:

Name:_____ Phone Number: _____

Address:_____

Primary Insurance Information

Health Insurance Carrier_____ Policy #_____ Group #_____

Name of Subscriber: _____Phone #_____

Subscriber's address_____

Subscriber's DOB: _____

Name of child's physician:_____

Phone number: _____

Does your child take any medications?_____

Religious affiliation:_____

How did you hear about KN Mental Health Services? _____

Has your child been to counseling before? _____ If so, was it helpful? _____

In a few words, what are you hoping to gain for your child? _____

_____

Family Members:

Name	Age	Relationship	Occupation/grade	Same Residence Y/N

History of Current Problem

Primary concern for your child? Duration? _____

_____

What have you already done to address this concern and how effective were these efforts?

_____

Was there a specific event that caused you to seek treatment now? _____

_____

(ICD-10): _____._____
_____._____
_____._____
_____._____
_____._____
_____._____