



**Wesley Center for Play Therapy
Parent/Child Intake Information**



Parent Information:

1) Full Name: _____ Preferred Name/Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

May we call? yes no

May we call? yes no

May we leave a message? yes no

May we leave a message? yes no

Best time to contact you? _____

Birth Date: _____ Age: _____ Sex: Male _____ Female _____

2) Full Name: _____ Preferred Name/Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

May we call? yes no

May we call? yes no

May we leave a message? yes no

May we leave a message? yes no

Best time to contact you? _____

Birth Date: _____ Age: _____ Sex: Male _____ Female _____

Marital Status: Single Married for _____ years Partners for _____ years
 Separated Divorced Widowed

Responsible Party Financial Information:

Self-Pay Sliding Scale: Income: _____

Discussed Fee for Services: _____

Scholarship: _____

Insurance ****IF INSURED****: Insurance Company: _____

Insured's Name: _____ Insured's D.O.B.: _____

Insured's Address: _____ Co-Pay: _____

Insured's Employer: _____ Billing Phone #: _____

Group Name: _____ Plan #: _____

Child Information:

Name: _____

Age: _____ Date of Birth: _____ male female

Custodial Parent (s): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (W) _____ (H) _____

Health:

Is your child currently under the care of a physician or a psychiatrist? yes no

Physician name: _____ Phone: _____

Psychiatrist name: _____ Phone: _____

List any medication your child is currently taking: _____

Date of last complete physical exam: Any significant results: _____

Physical Disability: yes no If yes, please explain: _____

Chronic Illness: yes no If yes, please explain: _____

Prior Counseling:

Have you or your child been in counseling before: If yes, when: _____

What was the nature of the problem?: _____

Do you feel that your child is or has been suicidal? yes no

Has anyone in your immediate family attempted or committed suicide? yes no

In case of emergency, who should we contact:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (W) _____ (H) _____ Relation: _____