The Center *for* Healthy Minds

Date: _____

Child's Full Name: _____ **Preferred Name** _____

Date of Birth: _____ **Age:** _____

Address: _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Child's Home Telephone: _____ **Child's Cell Phone:** _____

Grade: _____ **School:** _____

Referred by? _____

Parent/Legal Guardian #1

Mr. Rabbi Dr

Name: _____

Home Telephone: _____

Work Telephone: _____

Cell Telephone: _____

E-mail Address: _____

Social Security #: _____

Employer: _____

Parent/Legal Guardian #2

Mrs. Ms. Dr.

Name: _____

Home Telephone: _____

Work Telephone: _____

Cell Telephone: _____

E-mail Address: _____

Social Security #: _____

Employer: _____

Does your child have any allergies to medications? (If yes, please describe)

_____

Does your child have any medical problems? (If yes, please describe)

_____

_____

Is your child currently taking any medication regularly? (If yes, please list)

_____

Is your child regularly cared for by a physician? _____ **Physician Name:** _____

Physician Telephone: _____ **Physician FAX #:** _____

What Pharmacy do you use? _____ **Pharmacy Address:** _____

Pharmacy Telephone: _____ **Pharmacy FAX #:** _____