LARRY ROACH LMHC
Professional Counseling

Child/Adolescent Information
For Confidential Use Only

Name of Child/Adolescent: _____ **Date:** _____

Parent's or Legal Guardian's Information

Name(s): _____ Relationship to Child/Adolescent_____
Address: Street:_____ City:_____ State:___Zip:_____
Home Phone: _____Cell Phone: _____ Other Phone: _____
Email Address: _____
Name of person who referred you:
__
Religious Preference _____Church _____
Has anyone in your family been treated for a mental disorder? _____ Who? _____

I hereby give Larry Roach permission to provide counseling services for the child/adolescent mentioned above: Signature of parent or legal guardian: _____

Child's/Adolescent's Information

Child's/Adolescent's Date of Birth _____Age____ School_____Grade _____

Name of Siblings: _____Age____ _____ Age_____
_____Age____ _____Age_____

Briefly describe major reasons for coming to counseling and what you hope to accomplish:
_____
_____

Has child/adolescent received previous counseling from a Pastor, Psychiatrist, or other counselor?
Who? _____ When? _____

Physician's Name _____ Date of last physical exam: _____

Significant past medical conditions and years: _____

Current medical conditions (include any known allergies or dietary concerns):
_____
_____

Medications currently taken and for what reason: _____
_____
_____

Additional Information: