Roots & Wings
Consulting

Client Information Sheet (Child/Adolescent)

Name: _____

D.O.B.: _____ Social Security Number: _____

Address: _____

City, State, Zip: _____

Phones: Home: (___)_____ Work: (___)_____ Cell: (___)_____

Preferred Contact(s): ¦Home ¦Work ¦Cell ¦Any Best time to call: _____

Occupation: _____ Employer/School: _____

Parent Information:

Name:	Name:
Address:	Address:
Phone:	Phone:
Mother: Bio Step Foster Adoptive Other Foster/Adopt/Step/Other – How Long?	Father: Bio Step Foster Adoptive Other Foster/Adopt/Step/Other – How Long?
*Has authority to make medical decisions?	*Has authority to make medical decisions?

*In cases of divorce, separation, or foster parents, additional documentation may be requested

Insurance/EAP Information: (leave blank if we are not billing your insurance or EAP)

Insurance/EAP Company: _____ Through Employer:_____

Responsible Party Name: _____

Member ID Number: _____ Group Number: _____

Phone Number: _____

How many covered therapy/EAP sessions do you have? _____

***Medi-Cal/TERM:** Social Worker: _____Phone:_____

How did you hear about us?

_____