

**Lansing Psychological Associates, P.C.**  
234 Michigan Avenue  
East Lansing, MI 48823  
(517) 337-6545 FAX (517) 337-3010

**CHILD PERSONAL DATA SHEET**  
**(Birth through Age 17)**

Please complete the following. All material is confidential and will not be released except on your written request.

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt. No.

City State ZIP

Home Phone: Mother \_\_\_\_\_ Work Phone: Mother \_\_\_\_\_  
Father \_\_\_\_\_ Father \_\_\_\_\_

Cell Phone: Mother \_\_\_\_\_  
Father \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_ Male Birth Date: \_\_\_\_\_  
\_\_\_ Female Birth Place: \_\_\_\_\_

Grade: \_\_\_\_\_ School: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Occupation: \_\_\_\_\_

Mother's Address: \_\_\_\_\_  
Street City State ZIP

Father's Name: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

Father's Address: \_\_\_\_\_  
Street City State ZIP

Names and birth dates of child's siblings and/or stepsiblings: \_\_\_\_\_  
\_\_\_\_\_

Names, ages, and relationship of child to other people living in the home: \_\_\_\_\_  
\_\_\_\_\_

Who referred you here? \_\_\_\_\_

Has the child previously been seen at this clinic? \_\_\_ If yes, approx. how long ago? \_\_\_\_\_

Has the child received psychological treatment in another location? \_\_\_

If yes, when and with whom? \_\_\_\_\_

Please state briefly the questions or problems which prompted you to bring your child to the clinic at this time:

\_\_\_\_\_

Name and address of family physician: \_\_\_\_\_

Please list all medications currently being taking:

<u>Medication</u>	<u>Dosage and How Often</u>	<u>What Reason</u>	<u>How Long</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of last comprehensive physical examination: \_\_\_\_\_

Findings within normal limits? Yes \_\_\_ No \_\_\_ If no, specify problems/diagnoses: \_\_\_\_\_

Please list any disabilities your child has: \_\_\_\_\_

Please list any benefits (treatment and/or monetary) being received because of child's disabilities: \_\_\_\_\_

What allergies or sensitivities does child have? \_\_\_\_\_

Do you have insurance that will pay for psychological services? \_\_\_\_\_

Name of insurance company: \_\_\_\_\_

Policyholder's name: \_\_\_\_\_ Group Policy No. \_\_\_\_\_

Child's relationship to policyholder: \_\_\_\_\_ Policyholder's DOB: \_\_\_\_\_

Contract number or policyholder's social security number: \_\_\_\_\_

Policyholder's employer: \_\_\_\_\_

Service code or coverage plan number: \_\_\_\_\_

Please list any other health benefits or secondary insurances you may have: \_\_\_\_\_

In case of an emergency, please give name and address of a person you would like notified:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Street

Apt. No.

City

State

ZIP

*Please feel free to ask the receptionist or your therapist any questions you may have concerning any of the information requested.*