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Child/Adolescent Confidential Intake Form:

A. PERSONAL INFORMATION:

Date: _____

Child's Name: _____ Sex: (M)____ (F) _____

Date of Birth: _____ Age: _____

Mother's Name: _____ DOB: _____

Natural parent: _____ Relative: _____ Step Parent: _____ Adoptive Parent: _____

Father's Name: _____ DOB: _____

Natural parent: _____ Relative: _____ Step Parent: _____ Adoptive Parent: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____

Mom Work/Daytime: _____ Cell: _____

Dad Work/Daytime: _____ Cell: _____

E-mail: _____

Name of parent(s) or guardian(s) who have legal custody of child: (if same write "same as above")

Name and ages of all the people who live with your child, and their relationship to him/her:

Was your child adopted? Yes/No

If yes, at what age? _____

Mother's occupation? _____

Father's occupation? _____

Child's Emergency Contact: _____

Phone: _____ Relationship to child: _____

Child's School: _____ Grade/ Year: _____

B. INSURANCE INFORMATION:

Primary Insurance Company and ID#: _____

Group # (if applicable): _____

Name of Insured (if different from patient): _____ DOB: ___/___/___

Secondary Insurance Company and ID#: _____

Group # (if applicable): _____

Name of Insured (if different from patient): _____ DOB: ___/___/___

Do you wish for me to coordinate with your child's other providers? Y___ N___

If yes, with whom?

**If you would like me to share your child's health information with anyone other than his/her custodial parents/legal guardians, you will need to complete a Release of Information that authorizes me to do so.*

What are some of your concerns for your child right now?

Has the child ever been hospitalized for illness, physical ailments, emotional problems etc? Y___ N___

If yes, please explain where, when, and what for?

Has the child ever taken, or is he/she currently taking any medications? Y___ N___

If yes, please list medication name and frequency of dosage

Who referred you to me? _____

Signature of Parent: _____ Date: _____