MODIFY

Child Demographic Form

As we begin our working relationship, I would like to ask you to fill out the following form. To protect your confidentiality, none of this information will be disclosed and nobody will be contacted without your written permission.

Child's Name: _____ *Date of Birth:* _____ *Age:*_____

Gender Identity: ☐ *Female* ☐ *Male* ☐ *Transgender male* ☐ *Transgender female*

☐ *Non-binary/non-conforming* ☐ *Prefer not to respond*

Pronouns: ☐ *He/him/his* ☐ *She/her/hers* ☐ *They/them/their* ☐ *Use other pronouns:* _____

Sexual Orientation: ☐ *Straight* ☐ *Lesbian/gay* ☐ *Bisexual* ☐ *Asexual* ☐ *Unknown* ☐ *Other*

Parents' Name: _____

Address: _____

City: _____ *Zip Code:* _____

Home Phone: _____ *Cell Phone:* _____

Work Phone: _____

May we leave a voice message? ____ *Yes* ____ *No. If needed, please specify:* _____

Email: _____

Emergency Contact: _____

Address: _____

Phone: _____ *Relationship:* _____

Who referred you to our agency? _____

Primary Care Physician: _____ *Phone Number:* _____

Primary Insurance: _____ *ID#:* _____ *Group#:* _____

Gender (Insured): _____ *Date of Birth (insured):* _____

Secondary Insurance: _____ *ID#:* _____ *Group#:* _____

Gender (Insured): _____ *Date of Birth (insured):* _____