FRY HEALTH

ADOLESCENT INTAKE FORM

Date: ____

Name of Person Filling Out Form:____

Child's Full Name: ____

Child is Called: _____________Age: _______DOB: ____/_____/_____ Sex: Male Female

SS#:______________________ Present School: ________________________Grade: __________

Referred By: ____

Home Address:____

City: ______________________ County: __________________State: ________Zip: __________

Home Phone: _____________________Cell: __________________E-mail: ____________________

Brief Statement of Concerns: ____

____

____

Primary Care Physician: __________________________________Phone: ____________________

Child's Parents are: Living Together Separated Divorced

Father Deceased Mother Deceased Father Remarried Mother Remarried

This Child Lives With: __________________________Relationship to Child: ________________

Family Employment

Name of Employed Person	Place of Employment	Type of Work
1)		
2)		

Siblings:

Names	Age	Relationship	School Grade
1)			
2)			
3)			

Emergency Contact:

Name: ___________________Phone: _______________Relationship to Child:_________