CHARLES F. BRINAMEN, PSY.D.

Child/Family Contact Information

Today's Date _____

Child's Name: _____

D.O.B. _____ SS#: _____

Address: _____

_____

Home Phone: _____

School/ChildCare: _____ Phone: _____

Parents and/or Guardians

NAME	D.O.B.	RELATIONSHIP	IN HOME?	PHONE	EMAIL

Other Children in Home and/or Siblings:

NAME	D.O.B.	RELATIONSHIP	IN HOME?

Other Caregivers? (I will only contact with your prior written consent.)

NAME	AGE	RELATIONSHIP: Grandparent, teacher…	IN HOME?	PHONE

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Child/Family Contact Information

Other Health Care Professionals? (I will only contact with your prior written consent)

NAME	ROLE	PHONE	LOCATION
	Primary Care MD		
	Case Manager or Social Worker		
	Psychiatrist		
	Other/Former Therapists		

Mailing Address (if different from previous)

Street/Apt: _____

City/State:_____ZIP: _____

Contacting your family:
Are there special instructions for messages? [e.g. use first name only, never call after 8, cell phone only, etc.]

_____

_____

Emergency contact: Who should be contacted in case of Emergency in addition to parents/guardians?

Contact_____Ph:_____