Integrative Psychological Services, LLC

501 N. Frederick Suite 310 Gaithersburg, MD 20877

---------- Child/Adolescent Background Information----------

Patient Name: _____ Date: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: ___Male ___Female

Ethnicity: ___Asian ___Hispanic ___African-American ___Caucasian ___Other: _____

Name of Parent (s): _____

Complete Address: _____

_____

Contact Preferences:

Home Phone: _____ May I leave a message? Y/N

Cell Phone: _____ May I leave a message? Y/N

Email*: _____

May I email you? Y/N *Please be aware that email might not be confidential.

Does your child speak a language other than English? If so, is this his/her primary or secondary language and does he/she understand, speak or write: Well, Moderately Well, Not Very Well

Answer:

Please list school report submissions (email):

_____

_____

_____

_____

Signature Date