Dr. Caleb Loring
324 East St. John Street, Suite B
Spartanburg, SC. 29302

PARENT INFORMATION

Name _____ Date _____

Address_____ City _____ Zip _____

Phone: Home _____ Cell _____ Work _____

Preferred method of contact if necessary:_____

How and by whom were you referred:_____

CHILD AND ADOLESCENT INTAKE FORM

Background Information:

Name of Child: _____ Age: _____ Gender: _____

School Attended: _____Grade in School: _____

Special Education? Y N If "Yes", Classification? LD EBD Specify:_____

List all people now living in the household: (Use the back of this page if more space is needed).

Name	Relationship to Child	Age	Highest School Grade Completd	Occupation

If child does not live with both biological parents, describe custody arrangement: _____

_____

_____

Describe the problem. If possible, list questions for which answers are sought: _____

_____

_____

_____

_____

Has there been any previous psychological, psychiatric, or neurological evaluations or treatment? Y N
If so, please list name, address, and dates of contact:

_____

_____

Prior Diagnosis? Y N Diagnosed: _____ Date of Dx:_____

Medical History:

List sicknesses, operations, injuries. Indicate age when occurred and describe level of severity. Please include head injuries, any time when the child was unconscious, had convulsions, was delirious, or had a very high fever.

_____

_____

_____

_____

Gestation / Birth / Delivery: (Circle One) Normal Complications

If Complications, Describe: _____

_____

_____

Developmental Milestones: (Circle One) Within Normal Limits Delayed

If Delayed, Describe: _____

Therapies Child Has Participated In: _____

Consent for Treatment:

I declare that I am the custodial parent or legal guardian of the minor child described in this document. I have the legal authority to bring him/her in for psychological treatment, and I hereby give my consent for Caleb Loring, Psy.D. to provide psychological treatment for my child.

_____

Parent/Guardian signature

_____/_____/_____

Date