Floyd Covey, D.D.; Th. D.; Ph. D.; C. Carm. of C.T.P.; O.SS.T.
Bishop / Priest / Psychologist / Monk
Counseling from a Christian View
Soul Care and Wisdom Guidance

REGISTRATION FORM FOR A CHILD

PATIENT'S FULL NAME ____

AGE ______ DATE OF BIRTH ______________________ MALE ________FEMALE ________

STREET ADDRESS ____

CITY ________________________________ STATE _________ ZIP CODE _________________

HOME PHONE # ________________________WORK PHONE # __________________________

CELL PHONE # ________________ BEST NUMBER TO REACH YOU ____________________

FAMILY PHYSICIAN'S NAME ____

FAMILY PHYSICIAN'S PHONE / CITY ____

NAME OF PERSON OR AGENCY WHO REFERRED YOU TO US _______________________

CHILD'S SOCIAL SECURITY NUMBER ____

WHO HAS CUSTODY OF THIS CHILD? ____

MOTHER'S NAME ____

MOTHER'S ADDRESS ____

MOTHER'S PHONE INFORMATION:

HOME ____________________WORK ____________________CELL ____________________

PLACE OF EMPLOYMENT ____

ADDRESS OF EMPLOYER ____

____

OCCUPATION ____________________________ SS# ________________________________

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FATHER'S NAME ____

FATHER'S ADDRESS ____

FATHER'S PHONE INFORMATION:

HOME ___________________WORK _____________________CELL ____________________

PLACE OF EMPLOYMENT ____

ADDRESS OF EMPLOYER ____

____

The Lord is My Shepherd (Psalm 23:1)

OCCUPATION ______________________________ SS# ______________________________

PAGE TWO OF REGISTRATION FORM FOR A CHILD

PATIENT'S NAME ____

LEGAL GUARDIAN, IF NOT PARENT ____

GUARDIAN ADDRESS ____

GUARDIAN'S PHONE: HOME______________WORK_____________CELL_______________

RELATIONSHIP OF GUARDIAN TO CHILD ____________________________________

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NAME OF RESPONSIBLE PARTY____

RELATIONSHIP OF RESPONSIBLE PARTY TO CHILD ___________________________

ADDRESS OF RESPONSIBLE PARTY ____

HOME PHONE _____________WORK PHONE______________CELL PHONE ______________

RESPONSIBLE PARTY'S EMPLOYER ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY____

POLICY #____GROUP #_______________________

PHONE # OF INSURANCE COMPANY____

ADDRESS OF INSURANCE COMPANY____

____

NAME OF INSURED____

INSURED SS#____________________________INSURED BIRTHDATE__________________

RELATIONSHIP OF INSURED TO PATIENT ___________________________________

<> <> <> <> <> <> <>

SECONDARY INSURANCE COMPANY____

POLICY #________________________________GROUP #_______________________________

PHONE # OF INSURANCE COMPANY ____

ADDRESS OF INSURANCE COMPANY ____

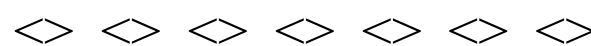
____

NAME OF INSURED____

INSURED SS#_________________________ INSURED BIRTHDATE ___________________

RELATIONSHIP OF INSURED TO PATIENT ___________________________________

PATIENT'S NAME____



EMERGENCY NOTIFICATION

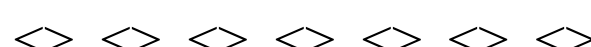
NAME OF CONTACT PERSON____

ADDRESS OF CONTACT PERSON____

____

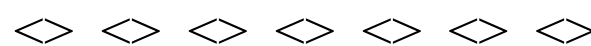
HOME PHONE______________WORK PHONE______________CELL PHONE_____________

RELATIONSHIP OF CONTACT PERSON TO CHILD____________________________________



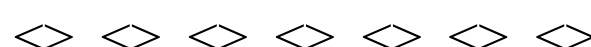
CHILD'S IMMEDIATE FAMILY (INCLUDE ALL PERSONS OTHER THAN PARENTS WHO LIVE WITH THE CHILD)

NAME	RELATIONSHIP	AGE



CHILD'S SCHOOL ____

CHILD'S GRADE: _______ CLASSES: REGULAR____RESOURCE_____SPEC. ED_____

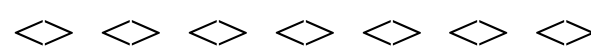


DOES THIS CHILD HAVE ANY MEDICAL PROBLEMS? ______________________________

IF YES, PLEASE EXPLAIN____

____

____



DOES THIS CHILD TAKE ANY MEDICATION____________IF YES, PLEASE LIST:

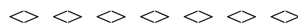
NAME OF MEDICATION	DOSAGE	FREQUENCY

PATIENT'S NAME: ____

Does this child have a history of previous mental health services? Yes _________ No __________

If yes, please list below

Type of Service	Dates	Provider
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

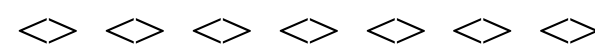


Does this child use alcohol or other drugs? _________YES ________NO

If yes, what does he/she use? ____

How frequently? ____

How much? ____



DOES THIS CHILD HAVE ANY LEGAL HISTORY? ___________YES __________NO

If yes, please explain: ____

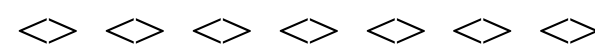
____

RELIGIOUS AFFILIATION____

PLEASE LIST THE CHILD'S LEISURE INTERESTS______________________________

____

____



BRIEFLY DESCRIBE THE PROBLEM(S) OR ISSUES FOR WHICH YOU BROUGHT THIS CHILD HERE: ____

____

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____

____

____

PATIENT'S NAME: ____

BRIEFLY DESCRIBE YOUR GOALS FOR THIS CHILD'S THERAPY_____________________

____

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____

____

IS THIS CHILD INVOLVED IN ANY SORT OF LITIGATION? ________ YES ________ NO

If yes, please explain: ____

____

____

PLEASE SHOW YOUR INSURANCE CARD TO THE RECEPTIONIST SO THAT WE CAN MAKE A COPY OF THE CARD.