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REGISTRATION FORM

Official Use:			
Medical Record #:		*Clinic:*	
Client/Patient Name:			Date: ____/____/_____
Mailing Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:	Email:	

Father's Name:	Mother's Name:
Father's Address:	Mother's Address:
City: State: Zip:	City: State: Zip:
Father's Home Phone:	Mother's Home Phone:
Father's Cell Phone:	Mother's Cell Phone:
Father's Email Address:	Mother's Email Address:

Date of Birth: ____/____/_____	Age:	Gender:	Insurance:
Ethnicity/Cultural Background: □ Hispanic □ Am. Indian □ African Am. □ Asian □ Indian □ API □ Caucasian □ Other: _____			
Languages Spoken at Home:		Preferred Language:	
Living Arrangement: □ House/Apt. □ Other: _____		Legal Custody: □ Mother □Father □Joint □Other _____	

Grade:	School:	IEP: □ Yes □ No □ Unknown 504: □ Yes □ No □ Unknown
Educational Placement: □ Regular □Therapeutic/Special Day Class □ Other _____		

Occupation:	Employer:
Physician's Name:	Physician's Phone #:
Date of last appointment with physician: Month _____ Year ____	Medical History:
Diagnostic History:	Medications:
Referring Person:	Referral Phone:

Reason for Referral/Current Concerns (please use back if necessary):