Name: ID#: DOB:

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CLINICAL & FORENSIC PSYCHOLOGICAL CONSULTING SERVICES (CFPCS, LLC)

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PARENT / ADOLESCENT REGISTRATION FORM

(**PLEASE PRINT OR TYPE)**

Today's date:		**Name of person completing this form:**			
Relationship to patient	☐ Self	☐ Mother	☐ Father	☐ Legal Guardian	☐ Other

PATIENT INFORMATION

Patient's Last name:		First Name:			Middle:
Is this patients legal name? ❑ Yes ❑ No	Nicknames/Preferred Name:	❑ Miss ❑ Ms. ❑ Mr.	Birth date: / /	Age:	Sex: ❑ M ❑ F
Place of birth		Native Language		Handedness ❑ Right ❑Left ❑Both	
Ethnicity:	☐ African American	☐ Asian	☐ Caucasian	☐ Hispanic	☐ Native American ☐ Other
Patient Street address:					
City:		State:	Zip:	Country	
Home phone: Ok to Call? Yes ❑ No ❑		Cell phone: Ok to Call? Yes ❑ No ❑		Best Time to Call: * (see below)	
* Calls will be discrete, please list any restrictions					
PARENT or GUARDIAN E-mail address? ❑ Ok to send email communications? Yes ❑ No ❑					

Who referred you? ☐ Doctor ☐ Hospital ☐ Family ☐ Friend ☐ Internet ☐ Other			
May I have permission to thank this person for your referral ☐ Yes ☐ No	If yes, please list name and contact info below		
First Name:	Last Name:		
Street Address:			
City:	State:	Zip:	
Phone:	Email:		

Name: ID#: DOB:

EDUCATION					
	FROM - TO	SCHOOL NAME	ANY SPECIAL CLASSES?	ADJUSTMENT TO SCHOOL	GRADUATED YES/NO
ELEMENTARY					
HIGH SCHOOL					
VOCATIONAL / TRADE					
COLLEGE					

Please describe any additional information regarding your child's education history which you think would be helpful:

_____

_____

_____

_____

Family History: Please indicate any psychiatric problems that **may exist** among relatives **that are biologically related to your child.**				
Disorder	**Mother**	**Father**	**Siblings**	**Other Biological Relative (specify)**
Depression				
Bipolar Disorder				
Suicide or Attempted Suicide				
Borderline Personality Disorder				
Anxiety Disorder				
Attention Deficit				
Schizophrenia				
Alcohol / Substance Abuse				
Other				

Name: ID#: DOB:

MEDICAL CARE & HISTORY

Month and year of child's last physical?	Any new problems or major findings?

Is your child currently being treated by a doctor or taking medications prescribed by a doctor? ☐ Yes ☐ No

If yes, state the problem or condition(s) being treated:

Please list any medications your child is currently taking, prescribed and over the counter.

Medication	Dosage	Prescribed and supervised by	Length of time taken

Primary Physician's Name:

I GIVE CONSENT TO CONTACT PHYSICIAN: ❑ Yes ❑ No	Phone:

Physician Street address:

City:	State	Zip

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ☐ Yes ☐ No	If yes: ☐ Medical	☐ Psychiatric

Dates From / To	Reason / Incident	Location/Facility

Please check which of the following substances you are aware your child has used

Substance and approx age of first use?

☐ Alcohol (Beer, wine, spirits, etc)	☐ Tobacco Products	☐ Pills, Ecstacy / Molly etc.
☐ Stimulants (Cocaine etc)	☐ Hallucinogens (LSD, PCP, acid, etc)	
☐ Inhalants (Glue, Gasoline, etc)	☐ Cannabis (Marijuana, hash etc)	

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HAS YOUR CHILD PREVIOUSLY HAD COUNSELING / MENTAL HEALTH TREATMENT ASSESMENTS? ☐ Yes ☐ No
If yes please list below

Disorder	Medications	For How Long?	Counselor	Helpful?
☐ Depression				
☐ Anxiety				
☐ ADHD				
☐ Bipolar Disorder				
☐ PTSD				
☐ Substance Use Disorder				
☐ Other				

Does your child have:

Any problems getting to sleep? ❑ Yes ❑ No Please Describe

_____

Any problems with appetite, eating, or gaining or losing weight recently? ❑ Yes ❑ No Please Describe

_____

Any allergies? ❑ Yes ❑ No Please Describe

_____

Any history of head trauma? ☐ Yes ❑ No Please Describe

_____

Any history of: ❑ Blackouts ❑ Bad reactions ❑ Withdrawal symptoms ☐ Overdoses ❑ Detoxification in a hospital

Please describe any additional information regarding your child which you think would be helpful for me to know:

_____

_____

_____

IN CASE OF EMERGENCY	
NAME OF LOCAL FRIEND OR RELATIVE	
RELATIONSHIP TO PATIENT	
I GIVE CONSENT TO CONTACT THIS PERSON REGARDING THE NATURE OF THE EMERGENCY ❑ Yes ❑ No	
HOME PHONE	CELL PHONE

Name: ID#: DOB:

FINANCIAL GUARANTOR (Person Responsible for Account)		
GUARANTOR NAME:		
Patient's Relationship to Guarantor: Child ____ Step-Child ____ Other ____		
Guarantor Street Address (IF SAME AS PATIENT, LIST SAME)		
City	State	Zip
Home Phone: Best Contact ☐	Work Phone: Best Contact ☐	Cell Phone: Best Contact ☐
Guarantor Email Address: Ok to contact ☐ Yes ☐No		Guarantor Social Security #

CREDIT CARD TO BE KEPT ON FILE: ☐ VISA ☐ MC ☐ AMEX ☐ OTHER

CARD NUMBER_____

NAME ON CARD_____

EXP. DATE_____ SECURITY CODE: _____ BILLING ZIP CODE: _____

UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE, THIS CREDIT CARD WILL BE CHARGED UPON THE COMPLETION OF SERVICES AND / OR AT THE END OF ANY MONTH FOR WHICH THERE IS AN UNPAID BALANCE DUE OVER AND ABOVE THE INITIAL RETAINER PAYMENT. I UNDERSTAND AND AGREE THAT A LATE OF $25 WILL BE ASSESSED FOR ANY UNPAID BALANCE MORE THAN 30 DAYS PAST DUE

I agree to pay in full for all services rendered on my / my child's behalf. I understand that Dr. Rafanello, CFPCS, LLC is ***not*** a participating provider with my insurance plan and is considered "out of network." CFPCS, LLC will provide a Billing Statement that I can file with my insurance provider for reimbursement. I understand and agree that payment for treatment is ultimately my responsibility.

I understand that 24 hours' notice of cancellation is required to avoid charges for missed appointments. I also understand that missed appointment fees are not covered by insurance plans.

The above information is true to the best of my knowledge.

PARENT / GUARDIAN / LEGAL REPRESENTATIVE SIGNATURE DATE

PARENT / GUARDIAN / LEGAL REPRESENTATIVE PRINTED NAME DATE