*Capital Psychological Services, LLC*

*5530 Wisconsin Avenue, Suite 1528*

*Chevy Chase, MD 20815*

*301-501-0130*

**CHILD INFORMATION**

Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City & State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT INFORMATION**

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from child):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*By providing an email addresses I am giving Sarah Berger, Ph.D. and Capital Psychological Services (CPS), LLC permission to make contact via email. I understand that email cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. I understand that Sarah Berger, Ph.D. and CPS, LLC do not accept liability for any errors that may arise as a result of email transmission.

Parent’s Relationship Status (please circle):

Single Significant Relationship Married/Partnered

Separated Divorced Widowed

Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTIVATION: Please give a brief description of the problem that led to seeking therapy at this time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How did you learn about Capital Psychological Services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do I have permission to contact this referral source (please circle)? Yes No

If yes, please provide contact information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact for child (not a parent): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give consent for my child to receive assessment/psychotherapy *(if parents are divorced with joint custody – both parents need to consent and sign)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian Date