

# Shannon E. Taylor PhD PA

North Texas Neuropsychology and Behavioral Medicine Services

9555 Lebanon Road, Suite 902

Frisco, TX 75035

214/872-4411 (phone)

844/270-4023 (fax)

www.drsetaylor.com

drsetaylor@yahoo.com



## Child and Adolescent Patient Information

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Gender : \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

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

Referred by: \_\_\_\_\_

Does the child live in the home with both of his or her biological parents? \_\_\_\_\_

If not, who is the child's primary caregiver? \_\_\_\_\_

For How Long? \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

What are the Custody or Guardianship Arrangements? \_\_\_\_\_

*Please provide documentation of custody or guardianship arrangements as applicable*

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Place of Business: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Place of Business: \_\_\_\_\_