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Child Patient Information Form

Child's Name: _____ Today's Date: _____

Parent's Email addresses: _____

Child's DOB: _____ Age: _____ SSN _____ - _____ - _____ School/Grade: _____

Mother: _____ DOB: _____ Age: _____ Father: _____ DOB: _____ Age: _____

Mother Home Phone No.: _____ Cell: _____ Father Home Phone No.: _____ Cell: _____

Patient Home Address : _____ City: _____ State: _____ Zip: _____ (No PO Box)

(Mother)Name of Business or Place of Employment: _____

Address: _____ City: _____ State: _____ Zip: _____

Business Phone: _____

(Father)Name of Business or Place of Employment: _____

Address: _____ City: _____ State: _____ Zip: _____

Business Phone: _____

Reason for requesting appointment: _____

Approximate date or time problem began: _____ Previous Therapy or Counseling: _____

List all current medications being taken: _____ Referred by: _____

Family Information (List all minor children's name, ages, date of birth and school they attend)

Name	Gender	Age	DOB	School	Grade

The person who initiates treatment is financially responsible for payment.

Signature _____ Date: _____