



Pediatric & Family Psychology, P.A.

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DATE COMPLETED: _____

CHILD/TEEN INFORMATION FORM

NAME: _____ F: ___ M: ___ AGE: _____

DATE OF BIRTH: ___/___/___

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE # (____) _____

HOME SCHOOLED: YES: ___ NO: ___ (If yes, please disregard "SCHOOL INFO" section.)

SCHOOL INFORMATION:

School: _____ Grade: _____

School Address: _____

Teacher(s): _____

Any Special Placement This Year: _____

Principal: _____ School Phone#: (____) _____

FAMILY INFORMATION (If living with someone other than parent, please specify):

PARENT/GUARDIAN NAME: _____

Date of Birth: ___/___/___

Street Address: _____

Occupation: _____ Employed By: _____

Home Phone#: (____) _____ Work Phone #: (____) _____

Cell Phone #: (____) _____

PARENT/GUARDIAN NAME: _____

Date of Birth: ____/____/____

Street Address: _____

Occupation: _____ Employed By: _____

Home Phone #: (____) _____ Work Phone #: (____) _____

Cell Phone #: (____) _____

SIBLINGS (names and ages): _____

PERSON RESPONSIBLE FOR PAYMENT: _____

MEDICAL INFORMATION:

Physician (s): _____

Address: _____

City: _____ State: _____ Zip: _____

Please list current medications:

Previous Mental Health Consultation:

REFERRAL:

Who referred you to this practice? _____

* PLEASE NOTIFY THIS OFFICE AS SOON AS POSSIBLE IF THERE ARE ANY CHANGES IN HOME & WORK ADDRESS, PHONE #'S OR CELL #'s.