

# LISA K. SCHKLOVEN, LCSW-C, LLC

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## REGISTRATION FORM FOR MINOR CHILD AUTHORIZATION FOR EVALUATION AND TREATMENT

Name:		Nickname:	
Street			
City/State/Zip:		Phone (H):	
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN#	Religion:
School Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Does not Attend School			
School Name & Address:			
City:		State:	Zip:
Phone Number:		Current Grade:	Years at This School:
<i>If child had attended any other schools, please list below. Include name of school, years of attendance and state, if not MD:</i>			
School:			
School:			
School:			

### **MOTHER'S INFORMATION:**

Mother's Name:		Date of Birth:
Address, if different from child:		Home Phone:
Occupation:		Work Phone:
Employer's Name/Address:		
Highest level of Education Completed:		Cell Phone:
Email/Other Contact:		

### **FATHER'S INFORMATION:**

Father's Name:		Date of Birth:
Address, if different from child:		Home Phone:
Occupation:		Work Phone:
Employer's Name/Address:		
Highest level of Education Completed:		Cell Phone:
Email/Other Contact:		

### **PARENT/GUARDIAN/CUSTODY:**

Parent's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Significant Other <input type="checkbox"/> Single	
If married or together, for how many years?	
<i>If parents are not married, who has <u>legal</u> custody of child?</i> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Joint <input type="checkbox"/> Other (explain):	
<b><i>PLEASE NOTE:</i></b> <i>In joint custody situations, written consent from both parents is required for treatment to occur.</i>	
<i>If parents live in separate domiciles, please list child's living arrangements and visitation schedules:</i>	
If <u>Separated</u> , How many years married prior to separation? How many years separated (if not divorced)?	If <u>Divorced</u> : How many years married prior to divorce? How many years have you been divorced?

How old was child at time of the separation/divorce?	How did child react to the separation/divorce?
By whom were you referred?	

**NAMES OF SIBLINGS/STEP-SIBLINGS: PLEASE USE THE BACK OF THIS PAGE, IF NECESSARY.**

Name:	Gender:	Relationship:	DOB:

**PLEASE ANSWER THE FOLLOWING QUESTIONS. PLEASE USE THE BACK OF THIS PAGE, IF NECESSARY.**

1. What are your concerns about your child for which you are seeking treatment at this time?

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2. What are your goals for treatment?

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3. Have you sought prior treatment for these concerns about your child? If so, please describe.

<u>Treatment Dates</u>	<u>Provider's Name</u>	<u>Outcome</u>

4. Is anyone in the family currently in treatment. If so, please list.

<u>Family Member</u>	<u>Provider's Name</u>	<u>Length of Treatment/Reason</u>

**AUTHORIZATION FOR EVALUATION AND PSYCHOTHERAPEUTIC TREATMENT OF A MINOR CHILD**

As the \_\_\_\_\_ parent(s) and/or \_\_\_\_\_ legal guardian(s) of the minor child:

Name of Minor Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I consent to his/her evaluation and/or psychotherapeutic treatment with Lisa K. Schkloven, LCSW-C, LLC.

Printed Name of Parent/Legal Guardian \_\_\_\_\_

Signature of Parent/Legal Guardian \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Date \_\_\_\_\_

Printed Name of Parent/Legal Guardian \_\_\_\_\_

Signature of Parent/Legal Guardian \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Date \_\_\_\_\_