Amy McMillan, MEd, LPC
610 W. Peace St.
Raleigh, NC 27605
(919) 244-0744
www.believeintherapy.com

Date _____

Referral source if applicable:_____

Patient's Name_____

Age: _____ **Date of Birth:**_____

School, Grade level, GPA:_____

Parent(s) Name(s) Including Stepparents: _____

Mother and/or Stepmother home, work, cell:_____

Father and/or Stepfather home, work, cell:_____

Patient home, work, cell:_____

Email Parents:_____

Email Patient if applicable:_____

Parents' Employment:_____

Responsible Party & Current Mailing Address:

_____

_____

Sibling names and ages (including half siblings and stepsiblings):

Current/Previous Mental Health Diagnosis:

Current Medications, Dosages, and who prescribed:

Primary Care Physician & Phone number:

Previous Psychiatrists or therapists:

Previous Hospitalizations (Hospital, Date, Reason for Admission):

Can you list goals and/or expectations of your child's therapy?(continue on back if needed)