

FamilyLight FACT SHEET

Child Complete Name: _____ Date of Birth: _____

Home Address (physical address preferred): _____ Current Grade Attending: _____

City: _____ State: _____ Zip Code: _____

Referred By Name: _____ Friend Clinician IECA Other Professional

Father Name: _____

Mother Name: _____

Address: _____
(physical address preferred)

Address: _____
(physical address preferred)

City/State/Zip: _____

City/State/Zip: _____

Home Phone: _____

Home Phone: _____

Home Fax: _____

Home Fax: _____

Home E-mail: _____

Home E-mail: _____

Mobile Phone: _____

Mobile Phone: _____

Occupation: _____

Occupation: _____

Business Phone: _____

Business Phone: _____

Business Fax: _____

Business Fax: _____

Business E-mail: _____

Business E-mail: _____

Other: _____

Other: _____

Please indicate the primary phone number for each parent:

Father: _____ Mother: _____

Therapist (1) Name: _____

Address (physical address preferred): _____

City: _____ State: _____ Zip Code: _____

Phone Number (1): _____ Fax Number: _____

Phone Number (2): _____ E-mail Address: _____

Last Appointment Date: _____ Length of Treatment: _____

Therapist (2) Name: _____

Address (physical address preferred): _____

City: _____ State: _____ Zip Code: _____

Phone Number (1): _____ Fax Number: _____

Phone Number (2): _____ E-mail Address: _____

Last Appointment Date: _____ Length of Treatment: _____

Treatment Schools, residential treatment centers, facilities, or hospitals where treatment may have taken place, including dates of treatment (please use an additional paper if necessary):

Please provide a short biography of your young person from infancy to the present.

