KARIN A. MOSK, PSY.D.
ASSESSMENT AND THERAPY FOR CHILDREN, ADOLESCENTS, AND ADULTS

Dr. Karin A. Mosk, Psy.D.
1125 West Street, Suite 208
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(410) 800-4237

BACKGROUND INFORMATION – CHILD

Date: _____

Child's Name: _____

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

Address:

Parent's Name: _____ **Soc. Sec.#:** _____-_____-_____ (if using insurance)

Address:

How to Contact You? **Check preferred method to reach you:**

Home Phone: _____ ☐

Cell Phone: _____ ☐

Work Phone: _____ ☐

Email Address: _____ ☐

Marital Status (of Parent)

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If parents are separated or divorced, who has legal custody? _____

If parents are living apart, name and address of alternate parent/legal guardian:

Education Information

Name of School: _____

Current Grade: _____

Teacher(s): _____

Child's Physician(s):

Name: _____

Address: _____

Phone: _____

Family Members

Parents:

Mother: _____ Age: _____

Father: _____ Age: _____

Siblings:

_____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

How did you hear about this office?

☐ Friend ☐ Family Member ☐ Doctor ☐ Teacher ☐ Website ☐ Workshop ☐ Other _____

Has the child or another family member ever been treated by a mental health professional?

☐ Yes ☐ No

If yes, who in your family? _____

When? _____

What was the purpose? _____

What was most helpful? _____

What was least helpful? _____

Current Concerns

Briefly describe your reasons for seeking psychological services for your child:

_____

_____

_____

_____

_____

Brief Questions

1. Are you concerned about your child's school performance? _____
2. Are you concerned about your child's emotional health? _____
3. How is your child's relationship with family members? _____
4. How is your child's relationship with peers? _____
5. What, if anything, would you change for your child if you could? _____
6. What do you hope to get from this service? _____
7. What concerns, if any, do you have about it? _____

Emergency Contact

Name: _____ Phone: _____

I have the right to request treatment for my child and I would like to open this file to discuss my child's health and development with Dr. Karin Mosk.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

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CREDIT CARD AUTHORIZATION FORM

Name: _____

Email: _____

Billing Address: _____

Billing City: _____ Billing State: _____ Billing Zip: _____

Billing Phone: _____

Name on Credit Card: _____

Credit Card Type: Visa____ MC____ AmEx_____ Discover_____

Credit Card Number: _____

Credit Card AVS Code (3 or 4-digit code): _____

Credit Card Expiration Date: _____(mm/yy)

Cardholder Signature: _____

Date: _____

I authorize Dr. Karin A. Mosk, Psy.D. to charge the amount of unpaid fees, including late cancellation fees. I assume responsibility for keeping current payment methods up to date. I also agree that I will pay for this purchase in accordance with the issuing bank cardholder's agreement.