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FAMILY INFORMATION

Child's Name _____ Date of Birth _____ Age _____ Sex _____

Home Address _____ City _____ Zip _____

School _____ Grade _____ Child's cell phone (if high school age) _____

Parent Email (used only for direct communication with Dr. Ruch) _____

Parent's Name _____ Age _____ Sex _____ biological adoptive

Phone(H) _____ (W) _____ (Cell) _____

Education _____ Employment _____

Parent's Name _____ Age _____ Sex _____ biological adoptive

Phone(H) _____ (W) _____ (Cell) _____

Education _____ Employment _____

Parent's Name _____ Age _____ Sex _____ biological adoptive

Phone(H) _____ (W) _____ (Cell) _____

Education _____ Employment _____

Parent's Name _____ Age _____ Sex _____ biological adoptive

Phone(H) _____ (W) _____ (Cell) _____

Education _____ Employment _____

Parent(s) with whom child lives _____

Others living in household (note age & relationship)

_____	_____
_____	_____
_____	_____

Child's Physician _____

Current Medications _____

Who referred you for this evaluation? _____

Previous Counseling or Evaluation _____

Reasons for seeking consultation _____

