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Intake Form

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Please provide the following information for my records. Leave blank any question you would prefer not to answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Child's name: _____

First Last Middle Initial

Name of parent/guardian:

_____

First Last Middle Initial

_____

First Last Middle Initial

Birth Date: _____ / _____ / _____ Age: _____ Gender: _____

Home Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Primary Phone: Home □ Cell □ (____)_____- May I leave a message? □ Yes □ No

Other _____: (____)_____- May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No

* Please be aware that email is not confidential. For scheduling purposes only.

Emergency Contact information:

Name:_____ Relationship: _____

Phone Number: (_____)_____

How did you find out about my services?:

□ Friend □ Another therapist/medical provider □ Online Therapy Directory

□ Blue Therapist Directory book

If from a directory or provider, which one: _____

May I thank them for referring you? □ Yes □ No

Is your child **currently** receiving psychiatric services (medication), professional counseling or therapy elsewhere?

□ Yes □ No If yes, current provider's name: _____

Has your child been in therapy before?

□ Yes □ No If yes, previous therapist's name: _____

Is your child **currently** taking prescribed psychiatric medication (antidepressants or others)?

□ Yes □ No If yes, please list:

_____

Has your child previously been prescribed psychiatric medication?

□ Yes □ No If yes, please list:

_____

Who prescribed it? _____

May I contact them? □ Yes □ No

Who is your child's primary care doctor? _____

May I contact them? □ Yes □ No

What are you seeking help for today regarding your child?

What are your goals for therapy for your child?

How are you/your child dealing with this now?

Any additional information that would help me in understanding what you are dealing with:

CURRENT ISSUES

Please indicate which of the following issues/problems your child is currently experiencing:

□ Depression
□ Sleep problems
□ Lack of friends
□ Stress
□ Suicidal thoughts □ attempt
□ Homicidal thoughts
□ Mood swings
□ Hallucinations
□ Anxiety
□ panic attacks
□ Body image problems
□ Eating disorder
□ Traumatic events
□ Victim of abuse (physical or sexual)
□ Grief/loss
□ Problems at work/school
□ Family conflict
□ Alcohol/substance abuse
□ Other: _____

Has your child had suicidal thoughts recently?

□ Frequently □ Sometimes □ Rarely □ Never

Has your child had them in the past?

□ Frequently □ Sometimes □ Rarely □ Never

In the PAST has your child ever experienced**:**

□ Depression
□ Sleep problems
□ Lack of friends
□ Stress
□ Suicidal thoughts □ attempt
□ Homicidal thoughts
□ Mood swings
□ Hallucinations
□ Anxiety
□ panic attacks
□ Body image problems
□ Eating disorder
□ Traumatic events
□ Victim of abuse (physical or sexual)
□ Grief/loss
□ Problems at work/school
□ Family conflict
□ Alcohol/substance abuse
□ Other:
_____
_____

In the last year, has your child experienced any significant life changes or stressors?

_____

PERSONAL AND FAMILY HISTORY

Significant people in your life (e.g., Parents, children, girlfriends/boyfriends, brothers, sisters, grandparents, step-relatives, half-relatives)

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□

_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□
_____	_____	_____	□	□	□	□

Parental Information:

□ Parents legally married □ Parents have ever been separated □ Parents ever divorced

□ Father remarried □ Mother remarried

Assessment of current parent-child relationship (if applicable): □ Good □ Fair □ Poor

Special circumstances (e.g., being raised by person other than parents, information about spouse/children not living with the child, etc.): _____

Family Mental Health History:

Has anyone in your child's family (either immediate family members or relatives) experienced difficulties with the following?:

□ Depression	□ Suicide Attempts	Other: _____
□ Bipolar Disorder	□ Trauma History	_____
□ Anxiety Disorders	□ Eating Disorders	_____
□ Panic Attacks	□ Learning Disabilities	_____
□ Schizophrenia	□ Alcohol/Substance Abuse	_____

Childhood:

Were there any special, unusual, or traumatic circumstances that have affected your child?

□ Yes □ No

If yes, please describe: _____

_____

_____

Has your child ever experienced child abuse? □ Yes □ No

If yes, which type(s)? □ Sexual □ Physical □ Verbal

If yes, was your child the: □ Victim □ Perpetrator □ Witness

Other childhood issues: □ Neglect □ Inadequate nutrition

□ Other (please specify): _____

_____

Other significant information: _____

SOCIAL RELATIONSHIPS

Check how your child generally gets along with other people: (check all that apply)

□ Affectionate □ Aggressive □ Avoidant □ Fight/argue often □ Follower

□ Friendly □ Leader □ Outgoing □ Shy/withdrawn □ Submissive

□ Other (specify): _____

Comments: _____

OCCUPATIONAL/SCHOOL INFORMATION:

Is your child currently a student?

□ Yes □ No If yes, school's name and current year/grade:

_____

Is your child currently employed?

□ Yes □ No If yes, who is your child's current employer/position?

_____

Please list any school/work related stressors, if any: _____

_____

HEALTH INFORMATION

How is your child's physical health at present?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches,

hypertension, diabetes, etc.):

_____

_____

_____

Is your child having any problems with sleep? □ Yes □ No

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other_____

How many times per week does your child exercise? _____

Approximately how long each time? _____

Is your child having any difficulty with appetite or eating habits? □ Yes □ No

If yes: □ Eating less □ Eating more □ Binging □ Restricting

Has your child experienced significant weight change in the last 2 months? □ Yes □ No

Does your child regularly use alcohol? □ Yes □ No.

If yes, how often? _____

How often does your child engage in recreational drug use? □ Yes □ No.

If yes, how often? _____

Additional Information:

_____

_____

_____

_____

_____