Intake Form

Please provide the following information and answer the questions below. Please note: This is protected confidential information. Please bring form to your first appointment. If you are unsure, leave the question blank and we will review it during your intake.

Name: ____
(Last) (First) (Middle)

Birth Date:____/____/____Age:______Gender:__________Nickname/Preferred Name: ______________

Marital Status:
☐ Never Married ☐Domestic Partnership ☐Married ☐Separated ☐Divorced ☑Widowed

Address: ____
(Street and Number) (City/State/Zip)

Home Phone: ( )____ ______________Messages ok? ☐Yes ☐No

Cell/Other Phone: ( ) ________________ Messages ok? ☑Yes ☑No

Email:____May we email you? ☑Yes ☑No

Emergency Contact Name:____________________________________Relationship: _________________

Emergency Contact Number: ( ) _______________

Referred By: ____

Preferred Method of Contact:____

Primary Insurance Carrier

Name of Insurer:____

Insurance ID #: ____________________Group #:_________ Effective Date of Policy:________ Co-pay Amount:______

Guarantor Information / if other than you:

Guarantors First Name:_____________________ M.I.:_____ Last Name:___________________ Date of Birth:________

Relationship to you:__________________ Phone: (_____)______-_______ Email:_______________________________

Home Address:___________________________________ City:_____________________ State:____ Zip Code:_______

Social Security Number / required for insurance claim:____

Secondary Insurance Carrier / if applicable

Name of Insurer:____

Insurance ID #: ____________________Group #:_________ Effective Date of Policy:________ Co-pay Amount:______

Guarantor Information / if other than you:

Guarantors First Name:_____________________ M.I.:_____ Last Name:___________________ Date of Birth:________

Name of person completing this form: ______________________________

Your relation to the child: ______________________________

Phone: ____________________ Email: ______________________________

Name of other parent/legal guardian: ______________________________

Phone: ____________________ Email: ______________________________

Child's first name: ____________________ Last name: ____________________

Ethnicity: ______________ Religion: ______________ Sex/gender: ______________

Who does your child live with?

____

ACADEMIC INFORMATION:

Name of child's school: ______________________________

Grade/year: ___________ Typical grades: ____________________

THE REASONS FOR YOUR CHILD'S VISIT:

____

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How intense is your child's emotional distress? (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please describe:

____

____

Overall, how much do the problems affect your child's ability to perform school, get along with others, and perform daily tasks such as chores?

(Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)

Please describe:

____

____

When did these problems start? What was going on in your child's life at that time?

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PSYCHIATRIC AND MEDICAL HISTORY

Please list any psychiatric or "mental" problems your child has been diagnosed with:

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____

Please list any medical or "physical" problems that your child has been diagnosed with:

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____

Please list any medications your child currently takes, and what they are taken for:

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Name of Psychiatrist: ______________________ Phone: ______________________

Last visit was during the month of: ______________ Year: ______________

Results:

____

____

MENTAL HEALTH TREATMENT HISTORY

Has your child ever been hospitalized for psychological or psychiatric reasons? ☐ No ☐ Yes

If yes, please describe when and where, and for which reasons.

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Please tell us about any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

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____

CURRENT HABITS

Please describe your child's current habits in each of the following areas:

Smoking: ____

Drinking: ____

Drug use: ____

TV use: ____

Internet use: ____

Video game use: ____________________

Caffeine intake: ____________________

Exercise: ____________________

Eating: ____________________

Sleeping: ____________________

Fun and relaxation: ____________________

Chores and responsibilities: ____________________

RELATIONSHIPS

Please describe your child's relationships with each of the following people, if applicable:

Biological Mother: ____________________

Biological Father: ____________________

Step-parents: ____________________

Legal guardians: ____________________

Siblings: ____________________

Extended family: ____________________

Your children: ____________________

Friends: ____________________

Romantic partner(s): ____________________

Colleagues or classmates: ______________________________

Total number of close, supportive relationships: ______________________________

STRESSFUL LIFE EVENTS

Please describe any significant or stressful life events that your child has been experiencing:

	No	Yes	If yes, please describe
A recent move or change in school?			
Abuse or neglect?			
Bullied or ignored by peers?			
Academic difficulties?			
Weight control issues?			
Sexual orientation concerns?			
Self-injury?			
Death or Illness of a loved one or pet?			
Family conflict?			
Separation or Divorce?			
Other?			

What are your child's positive qualities and skills? What do you like about your child? What qualities have helped your child to succeed at overcoming difficulties in the past?

Please tell us about your child's interests (sports, hobbies, talents, etc.)

Does your child agree that the problem that she or he is seeking help for is problematic?

What are some goals for your child's therapy? What would you like them to achieve by attending therapy?

What concerns do you have about your child attending therapy or working on these problems?

Is there anything else that you would like to mention?