I N T A K E F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Child/Adolescent's Name:

_____

Child/Adolescent (Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

Mother (Last) (First) (Middle Initial)

_____

Father (Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status Of Parents:

□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list siblings by first name and ages:

_____

_____

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

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

.

Referred by (if any): _____

Has your child/adolescent or any other family member previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner and outcome:

_____

_____

Is your child/adolescent currently taking any prescription medication?
□ Yes
□ No

Please list: _____

_____

Has your child/adolescent ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child/adolescent's current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your child/adolescent's current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week does your child/adolescent generally exercise? _____

What types of exercise: _____

4. Please list any difficulties your child/adolescent experiences with appetite or eating patterns:

_____

5. Is your child/adolescent currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Is your child/adolescent currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did he/she begin experiencing this? _____

7. Is your child/adolescent currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe _____

8. Does your child/adolescent drink alcohol more than once a week? □ No □ Yes

9. Does your child/adolescent engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Does your child/adolescent have any school problems? □ No □ Yes

Please describe: _____

_____

11. Please describe problem that brought you into treatment at this time:

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Panic Attacks	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Is any member of your immediate family experiencing symptoms of stress due to finances, work, illness or grief □ No □ Yes

If yes, what is your current situation:

_____

_____

_____

_____

_____

_____

2. How do family members view the problems being experienced by your child/adolescent?

_____

_____

_____

_____

_____

_____

3. What do you consider to be some of your child/adolescent's strengths?

_____

_____

_____

_____

_____

_____

4. What do you consider to be some of your child/adolescent's struggles?

_____

_____

_____

_____

_____

_____

5. What would you like to accomplish out of your child/adolescent's time in therapy?

_____

_____

_____

_____

_____

_____

_____