I N T A K E F O R M

Please complete this form for the person for whom the appointment was scheduled.

Please note: information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

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

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ SS#: _____

Others living in the home/age/relationship:_____

_____

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

May we send a text message? • Yes • No

E-mail: _____ May we email you? • Yes • No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
- No
- Yes, previous therapist/practitioner: _____

Is your child currently taking any prescription medication?
- Yes
- No

Please list: _____

_____

Has your child 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'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's current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. Please list any difficulties with your child's appetite or eating patterns

_____

4. Is your child currently experiencing overwhelming sadness, grief or depression?
- No
- Yes

If yes, for approximately how long? _____

5. Is your child currently experiencing anxiety, panic attacks or have any phobias?
- No
- Yes

If yes, when did you begin experiencing this? _____

6. What significant life changes or stressful events has your child or family experienced recently?

_____

_____

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	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Does your child enjoy school? Is there anything stressful about their current school situation?

_____

_____

2. Do you consider your family to be spiritual or religious? • No • Yes

If yes, describe your faith or belief:

_____

_____

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

_____

_____

_____

_____

4. What do you consider to be some areas of improvement for your child?

_____

_____

_____

_____

5. What would you like your child and your family to accomplish out of your time in therapy?

_____

_____

_____

6. Is your child currently having thoughts of hurting themselves or someone else? • No • Yes
If yes, please describe. _____

_____

_____

_____ _____ _____

Signature of person completing form *Relationship to client* *Date*