Intake Form

Personal info

Full Name: _____DOB: _____

Address: _____

Contact person for scheduling/updates: _____

Phone: _____ Email: _____

Insurance: _____

Ins ID#:_____

Chief Concern **Please describe the main issue that has brought you to see me:**

- **Are you currently involved in a CPS case? ___ Yes ___No**

Social Worker Name:_____

Attorney's Name:_____

- **Is this an EAP referral? ___Yes ___No**

EAP Company: _____ Case#: _____

- **Are you currently involved in a DOC case? ___ Yes ___No**

Probation Officer:_____

Name:_____

- **Are you currently involved in a Court Hearing?___ Yes ___No**

Civil/Who to contact:_____

Criminal/Who to contact:_____

Medical History:
What is the name of the clinic?

What is the name of your or child's medical doctor?_____

Address: _____ Phone:_____

Date of your last medical examination:_____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, Please describe them:

Have you or your child experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness	Other	

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? **YES, NO**

Your current employer

Employer:

Work phone:

Address:

Occupation:

Length of time with this employer:

Please indicate any restrictions on calls:

Education History: (If applicable)
What school does your child attend?

Address:

Phone:_____ Teachers Name:_____

Current Grade:_____

What does your child's teacher say about him/her?

Other schools attended (including Pre-school)

Has your child ever repeated a grade? If so which one(s)

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

fighting	lack of friends	drug/alcohol	detention
suspension	learning disabilities	poor attendance	poor grades
gang influence	incomplete homework	behavior problems	

Present relationships

How do you get along with your spouse or partner?

How do you get along with your children?

Family History:
The name of the child's biological parents:

Mother:_____ Father:_____

Who has legal guardianship of your child?

Who does your child currently live with?

Names	**Ages**	**Relationship to child**

Who are your child's significant others NOT living with your child?

Names	**Ages**	**Relationship to child**

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate:

When:

From Whom:

For What:

Results:

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

When

From Whom:

For What:

Results

List of Symptoms (Please circle any of the following that have been bothering you lately)

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	parenting issues	trauma
career choices	children	compulsions
compulsivity	change in concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage problems	memory	negative thoughts

nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	suicidal thoughts
self-esteem	separation	sexual problems
short temper	shyness	sleep
sadness	stress	work

Please indicate how the issue/s which you are seeking treatment are affecting the following areas:

Marriage / Relationship:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect 6 – Not Applicable

Family:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect 6 – Not Applicable

Job/school performance:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Friendships:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Financial situation:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Physical health:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Anxiety level / nerves:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Mood:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Eating habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sleeping habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sexual functioning:
1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Alcohol / drug use:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to concentrate:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to control anger:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Substance Use

Does anyone in the family currently (or in the past) consume alcohol? Yes No

If yes, (currently) on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Does anyone in the family have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about anyone in family drinking? Yes No

Does anyone Currently (or in the past) use any type of tobacco? Yes No Describe:

Does anyone currently (or in the past) use non-prescribed drugs or street drugs? Yes No

Does anyone have a history of problematic use of prescription or nonprescription drugs? Yes No

Is there a family history of alcohol or drug problems? Yes No

If yes, please describe:

Other History:

Has your child ever experienced any type of abuse/trauma (physical, sexual, or verbal? If so please describe:

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.