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Licensed Clinical Psychologist, CA#: 23829

Intake Information

Today's Date: _____

Name: _____

Date of Birth: ____/____/____ Age: ____ Sex: M F

Address: _____

Home Phone Number: (____) _____-_____

Cell Phone: (_____)_____-_____

Work Phone: (_____) _____-_____

Email: _____

Preferred mode of contact: Home phone cell phone work phone email

Who referred you: _____

Current Providers – Please provide their name(s) and contact information

I will not contact any of the listed providers without your written consent

Physician: _____

Psychiatrist: _____

Therapist: _____

Other: _____

Emergency Contact Information: (name, phone # and relationship to you)

_____

_____

Please describe the specific event(s) that led to you requesting treatment at this time, including specific problems or concerns you would like addressed at this time:

_____
_____
_____
_____

_____
_____
_____
_____

Please describe your strengths:

_____
_____
_____
_____
_____

Please list any areas of talent, hobbies, or organizations with whom you are involved:

_____
_____
_____
_____

Please write a brief history of when you first began experiencing the symptoms described above including the age at which they appeared and how the issue presented at that time:

_____
_____
_____
_____
_____

Instructions: Please fill out each section with the understanding that these issues will be further discussed at our appointment.

Medical and Physical Status

Current Height: Current Weight:
Females: Date of last period: _____ Are you pregnant? _____ Are you perimenopausal? _____ Having you entered menopause? _____
Current Illnesses/Treatment:
Are you currently receiving medical care, and if so, for what conditions:
Hospitalizations or serious injuries (e.g., concussions, etc):
Are there or have there been concerns related to speech development? If so, please describe.
Are there or have there been concerns related to fine or gross motor development? If so, please describe.
Are there or have there been concerns related to hearing or vision development? If so, please describe.

Is, or has, your child been especially sensitive to sensory input (e.g., lights, sound, touch, etc):
Please describe any issues related to sleep:
Please describe any issues related to eating or food choices:
Please describe any concerns related to daily habits (e.g., hygiene, use of free time):

Please list all current and past medications prescribed to your child including name, dose and length of time on the medication:

Name Dose Duration

_____
_____
_____
_____
_____
_____

Developmental History

Pregnancy: Please describe any complications during the pregnancy: Please describe any substance use during the pregnancy including alcohol, caffeine, tobacco use:
Delivery: Infant's gestational age: _____ weeks Birth weight: _____ Length: _____ What type of delivery method was used?

Was labor induced? Describe any complications during the delivery:
Infancy: Please describe your child's temperament as an infant: Did your child experience colic? If so, to what extent and for how long? Were there any feeding issues as an infant?

Educational History

Is your child currently in school? YES NO
Name of current school, address, phone number:
Child's current grade:
Does your child have a 504 Plan or IEP? YES NO If so, what accommodations are in place:
Is your child in a Gifted and Talented or other special education program: YES NO If Yes, please specify:
How is your child performing academically at this time? Have there been any recent and significant changes in academic performance? If Yes, please specify.
Child's favorite subject: Child's least liked subject:
Have there been any discipline problems in school including, but not limited to, suspensions, expulsions, grade repetition?

Social History

Does your child have a best friend? If yes, how long has this friendship existed?
How easily does your child make and keep friends?
What does your child like to do with friends/peers outside of school?

Mental Health History

Please list any previous <u>evaluations</u> and accompanying diagnoses (including age of child at time of evaluation/diagnosis and by whom):
Please describe <u>current interventions</u> targeting mental health issues including the name of provider, duration of treatment, and contact information:
Please describe <u>previous interventions</u> targeting mental health issues including the name of provider, duration of treatment, and contact information:
Has your child ever been hospitalized for psychiatric reasons? If yes, please describe when, where, for how long and the discharge plan:
Has your child ever been involved in an intensive outpatient or day treatment program? If so, where,

with whom, and for how long?

Has your child ever been taken to an emergency room or received in-home emergency assessment for threats to self or others? If yes, please describe situation, evaluation, and outcome.

Family Structure

With whom does your child primarily reside? If joint custody then please specify the legal custody arrangements.

Siblings:
First Name: _____ Age: _____ Gender: M F
First Name: _____ Age: _____ Gender: M F
First Name: _____ Age: _____ Gender: M F
First Name: _____ Age: _____ Gender: M F
First Name: _____ Age: _____ Gender: M F

Please describe your child's relationship with his/her siblings:

Family History

Is there a history of any of the following in your child's biological family (please indicate in whom, such as maternal aunt, paternal grandmother, etc):

- Depression: _____
- Bipolar Disorder (manic depression): _____
- Schizophrenia: _____
- Anxiety: _____
- Obsessive Compulsive Disorder: _____

- Tics or Tourette's: _____
- Suicide: _____
- Autism/PDD: _____
- Learning Issues: _____
- Anger Management Issues: _____
- Physical Abuse: _____
- Sexual Abuse: _____
- Mental Retardation/Slow learners: _____

Substance Use History

To your knowledge, has your child experimented with or used substances in the past or currently?
YES NO
(if Yes, please specify below)

Substance	Current Use	Last Used	Duration of Use	Frequency of Use
○ Alcohol				
○ Marijuana				
○ Tobacco				
○ Heroine				
○ Prescription pills				
○ Meth				
○ Ecstasy				
○ LSD				
○ PCP/Angel dust				
○ Other:				
○ Other:				

Legal History

Has your child had any legal involvement? YES NO

If Yes, please indicate for which of the following offense(s):

- DUI
- Traffic tickets
- Arrests
- Convictions
- Incarcerations

- Probation
- Gang activity
- Drug possession or sales
- Truancy
- Vandalism
- Violence against other
- Other

Please briefly describe the circumstances of the offense, resulting actions, and state of legal involvement at this time:

Abuse and Neglect

Has your child ever been physically abused: YES NO
If Yes, was the Department of Child and Family Services (DCFS) involved? And to what extent?

Was there police involvement? YES NO
What was the result?

Has your child ever been sexually abused? YES NO
If Yes, was the Department of Child and Family Services (DCFS) involved? And to what extent?

Was there police involvement? YES NO
What was the result?

Please list any other concerns or information that you think I should know about your child before we meet:

_____
_____
_____

_____

_____

_____

_____

_____