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INTAKE INFORMATION

Please print this entire document and bring it with you to your first session.

Child's Name _____ Birth Date _____
Primary Address_____ Current Age _____
City _____ State _____ Zip _____
School _____ Grade _____
Telephone (Home)_____ Child's Social Security Number _____
Medication Child is Currently Taking:

Name of Parent/Guardian _____ Home Phone _____
Cell Phone _____
Parent's/Guardian's Occupation (if applicable) _____
Address _____
Parent's/Guardian's Place of Employment _____ _____
Parent's/Guardian's Business Phone _____

Name of Parent/Guardian _____ Home Phone _____
Cell Phone _____
Parent's/Guardian's Occupation (if applicable) _____
Address _____
Parent's/Guardian's Place of Employment _____ _____
Parent's/Guardian's Business Phone _____

Child's Primary Residence is with: _____ _

Marital Status of Parents (Married, Divorced, Separated, Never Married, Other) _____
Joint or Shared Custody? Y N

_____

Others living in home with child, (ages and relationship to child) :

_____

If parents are separated or divorced, please complete the following:
How old was your child when parents separated? _____ divorced? _____
Are both parents aware of and in agreement about bringing your child in for this treatment? YES NO
If no, please explain. (Use back of paper if needed) _____ _____
Are both parents willing to participate in this child's therapy?_____

Referred by _____ Yes ☐ No ☐
May I contact this person to thank them for referring you here?

INTAKE INFORMATION CONTINUED (Please use back of paper as needed)

Please briefly describe your concerns about your child:

____
____
____
____

How do you feel these difficulties developed?

____
____
____

Does your child have any learning or medical problems? If so, please describe:

____
____
____

In order to help me understand your child better, please mark which of the two descriptions in each row is more like your child (Add notes on the back of the page, as needed):

☐ Calm, takes things in stride	☐ High stung, over reacts, worries
☐ Cheerful, always looks on the bright side	☐ Serious, somber most of the time
☐ Steady, stable mood	☐ Mood fluctuates unpredictably
☐ Low keyed, laid back	☐ High intensity, overwhelms people, loud
☐ Tends to likes new people and situations	☐ Initially withdrawn, dislikes new situations, shy
☐ Generally seems to feel safe and secure	☐ Frequently worries or feels anxious
☐ Fears are few and far between	☐ Many fears or frequent fears
☐ Flexible, handles changes and transitions easily	☐ Resistant to change, difficulty with transitions
☐ Can be energetic but also quiet for periods of time	☐ Rarely sits still, always on the go
☐ Focused, usually concentrates well	☐ Distracted easily, forgetful, disorganized
☐ Can persist towards goals, but can accept "no"	☐ Stubborn, argumentative
☐ Very regular rhythms (eating, sleeping, etc.)	☐ Irregular or unpredictable rhythms (eating, sleeping, etc.)
☐ Careful, takes his/her time on things	☐ Impulsive, acts without thinking
☐ Slow to anger	☐ Quick to anger
☐ Handles anger appropriately for age	☐ When angry, becomes aggressive (hits, bites, throws, etc)
☐ General behavior is usually appropriate	☐ Often silly, goofy or inappropriate
☐ When upset, responds to efforts to calm him/her	☐ When upset, parent's efforts to calm child increase upset
☐ Can calm down when upset in reasonable time	☐ Remains upset, sad, mad, etc, for a prolonged time
☐ After upset, child is able to move on	☐ After upset, child feels excessively guilty or blaming
☐ Normally careful with own body	☐ Engages in risky/dangerous activities
☐ Has good self esteem	☐ Has low self esteem
☐ Eats normally	☐ Eats excessively or eats very little
☐ Falls asleep shortly at bedtime, stays asleep	☐ Can't fall asleep and/or wakes during the night
☐ Wakes in morning and rises in short time	☐ Difficulty waking and/or rising in the morning
☐ Allows others to be in control	☐ Wants to be in control all of the time
☐ Learns from experience	☐ Does not seem to learn from experience
☐ Socially adept	☐ Socially awkward, doesn't seem to read social cues
☐ Not bothered by much	☐ Very fussy about one or more types of sensory stimuli circle which one(s): sounds, smells, touch, food, other

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Is your child currently taking any medication for any condition? Has your child taken medication in the past for emotional or behavior conditions? If so, please describe (type, dosage, frequency, prescribing physician, and condition):

_____
_____
_____

Please note: Please advise me any time there is a change in the medications your child is taking.

PAYMENT INFORMATION:

Person Responsible for Payment _____
Soc Sec # _____

My signature below indicates that the above information is correct and accurate to the best of my knowledge. I permit copies of this authorization to be used in place of the original. I understand that I have the right to revoke this authorization at any time by presenting written notification to this office. *This authorization is valid for the duration of treatment and until any and all payment issues are resolved.*

_____ _____ _____
Child's Name Signature of Parent/Guardian Date