**Julie Maccarin, Ph.D., OT/L**

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**INTAKE INFORMATION Please print this document and bring it with you to your first session.**

Name Birth Date

Primary Address

City State \_\_\_\_\_\_\_\_ Zip

# Cell Phone Home Phone

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others living in home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Marital Status (Married, Divorced, Separated, Never Married, Other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If a parent, please complete the following:**

Names and ages of your child/children \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you experienced any significant stressors in recent years: (losses, births, deaths, separation or divorce, significant illnesses, moves, hospitalizations, financial problems, etc.)? Please describe.

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Have you ever experienced a significant trauma? If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you previously received counseling or therapy? If so, when and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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HISTORY

Please describe your general health:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you currently have sleep problems? Please describe.

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Do you currently have eating concerns/food issues and/or weight problems? Please describe.

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Do you have any medical problems? If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Would you describe yourself as (circle all that apply):

Withdrawn Hyperactive Disruptive Anxious Frightened

Depressed Lonely Sad Stubborn Inattentive

Angry Defiant Friendly Playful Happy

Aggressive Bullied Self deprecating Irritable Impulsive

Are you concerned that you have a problem with (circle all that apply):

Family grief/loss Regulating emotions Dealing with a traumatic event Phobias

Making friends Getting along with peers Getting along with siblings

Transitions Coping skills Processing/following instructions

Academic skills Stealing Lying Gender identity

Being safe Self esteem Panic attacks Sexual behavior

Somaticizing (having stomach aches or other physical problems for which there is no medical explanation)

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark which of the descriptions in each row is more like you (Add notes on back, if needed):

Calm, I take things in stride High strung, I over react, worry

Cheerful, I always looks on the bright side I am serious, somber most of the time

I have a steady, stable mood My mood fluctuates unpredictably

I am Low keyed, laid back I am intense, I sometimes overwhelm people

I tend to likes new people and situations I am initially withdrawn, I dislike new situations, I’m shy

I generally feel safe and secure I frequently worry or feel anxious

My fears are few and far between I have many fears or frequent fears

I’m flexible, I go with the flow I have difficulty with new situations and/or transitions

I can be energetic but also quiet for periods of time I rarely sits still, always on the go

I can focus, I usually concentrate well I am distracted easily, forgetful, disorganized

I can persist towards goals I tend to be stubborn, argumentative

I have very regular rhythms (eating, sleeping, etc.) My rhythms are irregular or unpredictable

I am careful, take my time on things I tend to be impulsive, act without thinking

I am slow to anger I am quick to anger

I handle anger appropriately When angry, I become aggressive

My behavior is usually appropriate  I am often silly, goofy or inappropriate

When upset, I am able to calm down quickly/easily When upset, it takes me a long time to calm down

After upset, I am able to move on After upset, I feels guilty or blaming

I am normally careful with my own body I like to engage in risky/dangerous activities

I have good self esteem I have low self esteem

I fall asleep shortly at bedtime and staysasleep I can’t fall asleep and/or I wake often during the night

In the morning, I wake and rises easily I have difficulty waking and/or rising in the morning

I feel I am socially adept I feel socially awkward

I am not bothered by much I am very fussy about one or more types of sensory stimuli circle which one(s): sounds, smells, touch, food, other

Do you or your family members have:

Yes No Self or which family member or members?

Learning Problems \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADD/ADHD \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Autism spectrum \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Self or which family member or members?

Depression \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Addiction \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other psychiatric conditions \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious medical problem \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genetic abnormality \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PHYSICIAN INFORMATION**

My physician is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do \_\_\_\_\_\_\_\_ do not \_\_\_\_\_\_\_\_ give Dr. Maccarin permission to share basic information about my treatment with my physician. (Please initial your choice)

**MEDICATION**

Are you currently taking any medication(s) for any condition? If so, please describe (type, dosage, frequency, prescribing physician, and condition):

Have you taken medication in the past for emotional or behavior conditions? If so, please describe (type, dosage, frequency, prescribing physician, and condition):

Note: Please advise me any time there is a change in the medications you are taking.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRAL INFORMATION**

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I contact this person to thank them for referring you here? Yes No

Would you like me to share information about you with this person? Yes No

**PAYMENT INFORMATION:**

Person Responsible for Payment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Name Signature Date

**Acknowledgement Of Receipt Of Hippa Compliant Notice Of Privacy Practices And Consent**

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), a Notice of Privacy Practices is included on the website ChildPsychologyMarin.com, which details how health and clinical information may be usedfor the purposes of Treatment, Payment, Health Care Operations and other purposes. As more fully explained in that document, you may have the right to request restrictions on how I use and disclose your protected health information. I are not required to agree to requests, however, if I do, that request does not include use of information that may be needed to provide emergency treatment to you. I reserve the right to change my privacy practices in accordance with the HIPAA Privacy Rules; the terms contained in the Notice Of Privacy Practices may change also. If this occurs, those changes will be posted on the above named website, indicating the effective date. A copy of the new Notice of Privacy Practices will be provided to you at your request.

My signature below indicates that I have received the Notice Of Privacy Practices of ChildTherapyMarin. I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that the information has already been used or disclosed in reliance on this consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Signature Date