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Welcome! Please complete these forms and bring them with you to your child's first appointment. When you arrive at the office, you will find a row of light switches on the wall. Find my name next to the correct switch, and turn it on. This will let me know you have arrived. Have a seat in the waiting room, and I will be with you soon.

Intake Information

Today's Date: ________________________ Your Name: ______________________________________

Your relationship to the child: ____

Home Address: ____

If different, child's home address: ____

Your contact phone: ____________________________________ CELL HOME WORK OTHER ______

May I leave a message? YES NO

Alternate phone: ____ May I leave a message? YES NO

Your e-mail address: ____

Your preferred method of communication: PHONE EMAIL OTHER ________________________

How did you hear about my practice?

____ Friend or acquaintance

____ Referring provider, if so, provider's name: _______________________________

____ Internet search

____ Other, specify: ____

Child/Adolescent's Biographical Information

Child's Name: ____

Date of Birth: ___________________________ Age: ____________________________

Child's contact phone: ____ CELL HOME OTHER ________

Child's e-mail address: ____

Child's preferred mode of communication, if applicable: PHONE E-MAIL TEXT OTHER ____

Ethnic/Cultural Identity: ___________________ Language(s) spoken in the home: _______________

Gender Identity: ____

Parent(s) relationship status: ____

Who is the child's legal guardian(s): ____

Who has physical custody of the child? ____

Was child adopted? (circle) YES NO If yes, at what age? ___________________________________

Child's School Information

School Name: ____ City: __________________________________

Grade: __________ How is your child doing in school? ____

Does your child have social or behavioral problems at school? (circle) YES NO

If yes, specify ____

Has your child ever been held back at school? (circle) YES NO

Does your child have any learning disabilities? (circle) YES NO

If yes, specify ____

Does your child have an IEP (Individualized Education Plan) or 504 Plan? (circle) YES NO

Family Information

Please list all the people currently living in the same household with the child, including non-family members.

Name	Age	Relationship to Child

Second Home (if applicable). List all the people currently living in the child's second home:

Name	Age	Relationship to Child

List other significant people who do not live in the homes above:

	Name	Age	City and State
Parent(s) not living in child's home			
Sibling(s) not living in child's home			
Grandparents			
Caretakers			
Others			

Birth and Developmental Information

Was child full term? (circle) YES NO If no, number of weeks when born _______________

Did mother experience any complications with any of the following? If so, please describe:

YES **NO** Pregnancy ____
YES **NO** Labor ____
YES **NO** Delivery ____
YES **NO** Postpartum Issues ____

Did child experience any delays with any of the following? If so, please describe:
YES **NO** Walking ____
YES **NO** Talking ____
YES **NO** Toileting ____
YES **NO** Muscle coordination ____
YES **NO** Social relationships ____

Has child had a history of any of the following? If so, please describe:
YES **NO** Sleep problems: ____
YES **NO** Temper tantrums ____
YES **NO** Eating problems ____
YES **NO** Unusual crying spells ____
YES **NO** Refusing to go to school ____
YES **NO** Aggressive behavior ____
YES **NO** Oppositional behavior ____
YES **NO** Special fears ____
YES **NO** Other problems ____

What forms of discipline do you use with your child?
____ Time Out ____ Loss of Privileges ____ Physical Punishment
____ Ignoring ____ Grounding ____Other, describe: ________________________

Health & Social Information

How would you describe child's physical health? (circle) EXCELLENT GOOD FAIR POOR

Does your child have a Primary Care Physician? If yes, Name/phone number?

____

Has child had any significant medical problems, now or in the past? _________________________

____

Does child have any chronic or recurring medical conditions? _______________________________

____

Has child ever been hospitalized for medical reasons? _____________________________________

____

Has child experienced any other significant medical issues (serious injuries, loss of consciousness, surgeries, etc)? ____

Is child currently under the care of a psychiatrist? If yes, Name, location, phone number:

____

Has child ever been hospitalized for psychiatric reasons? ___________________________

____

Is child currently taking any medications (including psychiatric medication)? __________

____

Has child taken psychiatric medication in the past? _____________________________

Has child ever attempted suicide or tried to harm self? ___________________________

____

Has child had problems with substance use (alcohol, prescription medications, recreational drugs)? ____

Has child ever been in a physical fight that resulted in injury to self or others? _________

____

Has child ever been injured or hurt by physical or sexual abuse? ___________________

____

Have there been any deaths or separations from people with whom the child had a close relationship or frequent contact? If yes, please explain: ___________________________

____

Have any family members has emotional/mental health issues? If yes, please indicate relationship to child and nature of the issues: ____________________________________

____

Have any family members had problems with alcohol or drugs? If yes, please describe: ____

____

Is your child struggling with any of the following? Please check those that apply.

____ Sad/Depressed Mood	____Sleep Issues	____ Shyness
____ Worries/Anxiety	____ Hyperactivity	____ Hearing voices
____ Withdrawn	____ Nightmares	____ Social skills
____ Physical Aggression/Fighting	____ Academic Performance	____ Alcohol/drug use
____ School attendance	____ Bullying	____ Stealing
____ Seeing things others don't	____ Lying	____ Trauma
____ Inappropriate sexual behavior	____ Oppositional/defiant	____ Suicidal thoughts
____ Conflict in family relationships	____ Self-injurious behavior	____ Excessive clinging
____ Wetting/soiling bed/pants	____ Bereavement	____ Running away
____ Poor Attention/Concentration	____ Irritability	____ Parental divorce
____ Developmental delays	____ Appetite changes	____ Repetitive behaviors
____ Difficulty relating to peers	____ Restricted Eating	____ Binging/Purging

The pain and distress caused to *my child* by his/her problem(s) is:
____ Very Mild ____ Mild ____ Moderate ____ Severe ____ Very Severe

The pain and distress caused to *others* by my child's problem(s) is:
____ Very Mild ____ Mild ____ Moderate ____ Severe ____ Very Severe

Has child ever participated in psychotherapy? YES NO If yes, when and for how long?

____

Please describe what concerns bring you in today, on behalf of your child?: ____________

____

____

When did these difficulties begin? Did any particular event seem to trigger them? ______

____

What have you already tried to solve these concerns? ______________________

____

What are your child's greatest strengths? ____________________________

____