Intake Information Form

Attached are forms, regarding the nature of your concerns, that will help in providing you with the appropriate services.

The first three pages are addressed to you, the adult who is accompanying a child or teen to obtain services. Please complete these forms by providing information on your current circumstances and history, as well as your concerns.

The next page (Medical Screening Form) are about your child and his/her family. Please complete these forms accordingly.

The next sheet is for your child to complete regarding his/her own problems or concerns. If your child is too young to complete the form, you may do so yourself, or offer any assistance that is needed.

All information is held in strict confidence.

Please have this form completed by your next visit and bring it with you.

Please complete the following pages for yourself, the adult who is accompanying the child.

Parent/Guardian's Name: Age: Date:
Relationship to child (circle one): Parent Guardian Other
Address:
Home phone: Work phone: Ok to leave message? Ok to leave message?
Cell phone: Email Ok to leave message? Ok to email?
Preferred method of contact: Home phone Work phone Cell Email
Date of birth: Sex: Occupation:
Parent/Guardian's relationship status: Single Separated Widowed Married Divorced Partnered
(Parent/Guardian) With whom do you currently live? (Circle all that apply) Live alone Friend(s) Children Spouse/Partner and Children Spouse/Partner Parents Other relatives Other (please specify):
Parent/Guardian's education: Some high school High school graduate Some college B.A. Graduate degree
Parent/Guardian's religious background (optional) Buddhist Hindu Muslim Catholic Jewish Protestant Other (specify):
Parent/Guardian's ethnic background (optional): Native American Caucasian Pacific Islander/Asian African American Latino Other (specify):
Has the child previously received psychological or psychiatric help or counseling?
Has the child previously received psychological assessment (testing)? Please describe.
Has any other member of your family or household previously sought or received psychological or psychiatric help or counseling? Please describe.
How did you hear about us?

Family information

Spouse/Partner Name:	Age: Date:
Children (Please list all children whether living with you or not) 1. 2. 3. 4. 5.	Age:
Emergency contact name: Address:	Phone number: Relationship to child:

Problem areas.

Please rank up to 3 problems of most concerns to you regarding your child at this time. Place a "1" next to the problem that troubles you the most, a "2" next to the second most troubling problem and a "3" next to the third most troubling problem.

Educational or vocational choice	Uncontrollable or disturbing thoughts
Employment/Finances	Physical conditions (pain, headaches, insomnia)
Friendships or social life	Anxiety (worries, fears, phobias)
Marriage or couple	Physical or sexual abuse
Family	Habits
Sex	Educational problems or learning disabilities
Legal/Criminal	Eating issues
Memory or concentration	Depression
Behavior problems (attention problems, delinquency)	Other (please specify

How do you feel we can best help you and the child?

I certify that the above information is correct to the best of my knowledge.

_____ _____

Signature Date

Child Medical Screening Form

Name of child: Birthdate: Sex:
Is your child currently receiving medical care? Y N If yes, please describe briefly:
Name of physician in case of emergency: Phone:
Major childhood illnesses:
Other major illnesses or handicaps:
Hospitalizations or serious injuries: Reason: When: Complications or continuing problems (if any):
Current drugs or medications: Name of medication Dose per day Date started 1. 2. 3. 4.
Have there been any serious illnesses, accidents, deaths or other physical concerns within your family in the past 5 years? Y N If yes, please specify:
If there are any other medical or physical problems which you feel might be important to our ability to be of help to your child/teen, please explain here:

Youth Form (under 18 years old)

Name: Age: Grade in school: Date of birth:
Religious background (optional) Buddhist Hindu Muslim Catholic Jewish Protestant Other (specify):
Ethnic background (optional): Native American Caucasian Pacific Islander/Asian African American Latino Other (specify):
Have you ever had counseling or psychotherapy before? Y N
Have you ever had psychological testing before? Y N

Problem areas: Please put a "1" next to the area listed below that you are most worried about or is the biggest problem for you. Put a "2" next to the second most troubling problem and put a "3" next to the third most troubling problem.

Doing school work or homework	Problems with friends
Getting in trouble at school	Feeling badly about yourself
Paying attention	Special worries or fears
Problems sleeping	Dating problems
Problems eating (too fat, too thin)	Problems with drugs or alcohol
Bed wetting or soiling	Problems with sex
Problems with parents	Getting in trouble outside of school or with the law
Problems with brothers or sisters	Decisions about the future (work or school)
Other (please specify):	

In your words, tell what you are worried about or what you think are problems for you: