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Seen by Appointment Only

INTAKE HISTORY & BACKGROUND INFORMATION

Date_____

Client Information:

Child's Name_____

Child's D.O.B_____ SSN_____

Primary Home Address_____

City_____State _____ Zip _____

Guardian Information:

Name_____

Home Phone _____

Work Phone _____

Cell Phone _____

Please circle or asterisk your preferred telephone contact number.

May I leave a message on your preferred number, above? Yes/No

E-mail _____

Is this a private/secure e-mail account? Yes/No

Name(s) of those living in household	Relation to Client (Child)	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How were you referred?

_____

Has your child had previous counseling? Yes / No

With Whom?_____When? _____

Briefly describe the issues or difficulties for which you are seeking help:

_____

_____

_____

Medical History Questionnaire:

Current Physical Health—On a scale of 1 (very poor) to 10 (excellent) how would you rate your present health? (circle one)

1 2 3 4 5 6 7 8 9 10

Who is your primary care physician?

_____

What prescription medications are you currently taking?

_____

What non-prescription medications are you currently taking?

_____

Mental Health Questionnaire:

Please answer each of the questions below by circling the appropriate number appearing at the right side of the page. Each of the items should be answered according to how you currently feel, or have been feeling in the last few weeks:

	Poorly				Very Well/Good
How well is your child sleeping?	1	2	3	4	5

	Low				High
How would you describe your child's energy level?	1	2	3	4	5
How high is your child's current stress level?	1	2	3	4	5
	Hopeless				Very Bright
How does your child's future look to them?	1	2	3	4	5
	Sad				Happy
How would you describe your child's recent moods?	1	2	3	4	5
	Disappointed				Satisfied
How does your child generally feel about themself?	1	2	3	4	5

Does your child typically worry a great deal? Yes / No

Have they been very nervous or anxious recently? Yes / No

How would you describe your child's relationship with their:

	Poor				Excellent
Parents	1	2	3	4	5
Siblings	1	2	3	4	5
Extended family	1	2	3	4	5
Friends	1	2	3	4	5

Do they have trouble concentrating? Yes / No

Do they have trouble making decisions? Yes / No

Do they have trouble remembering things? Yes / No

Who may I contact in case of emergency?

1) Name _____

Phone_____

2) Name _____

Phone_____

Is there anything else you would like for me to know about your child?

_____

_____

_____

_____