Case No. _____
Referred By _____

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Parent/Child Intake Information Form

Child/Adolescent Information

Today's Date: _____

Name:	Date of Birth: Age:
Home Address:	
City:	State: Zip:
Home Tel:	Mobile Tel:
E-mail:	School:
Emergency Contact (name and phone):	Grade:
	Social Security Number: - -

Please comment on your child's school performance: _____

_____

_____

Parent/Guardian Information

Name:	Relationship to Child:
Home Address:	
City:	State: Zip:
Home Tel:	
Mother's Information	**Father's Information**
Name	Name
Mobile Tel: Work Tel:	Mobile Tel: Work Tel:
E-mail:	E-mail:
Social Sec#:	Social Sec#:
Occupation:	Occupation:
Employer:	Employer:

Empl Tel #:	Empl Tel#:
Spouse/Sig Other:	Spouse/Sig Other:
Address if different	Address if different

Parents are currently: Married Divorced Remarried Never married Other: _____

Child's custodian/guardian is: _____

Stepparent(s) Name(s)/Age(s): _____

Sibling(s) Name(s)/Age(s): _____

Insurance Information

PRIMARY INSURANCE:	Policy Holder's Name:
Claims Address:	Relationship to Client
City/State/Zip	I.D.#:
Claims Phone #:	Group#:
SECONDARY INSURANCE:	Policy Holder's Name:
Claims Address:	Relationship to Client
City/State/Zip	I.D. #:
Claims Phone #:	Group #:

Please list all of the members of your household

Name	Relationship	Employment/School	Age

Additional People in your life or your child's life who play an important role:

_____

_____

PRESENTING CONCERNS

Briefly describe your reason(s) for seeking help for your child:

_____

_____

_____

How long has this occurred? _____

How severe are your child's symptoms? Mild Moderate Severe

How have you attempted to resolve these concerns?_____

Has your child been treated by other mental health professionals? Yes No

If so, when and for how long?_____

Is your child taking any medications for this concern? Yes No

If so, list medications:

_____

What are your goals for counseling (answer the question only if you came to see me for therapy and not testing)?

_____

CHILD'S CURRENT HEALTH

Primary Care Physician: _____ Phone: _(___)_____

Height: _____ Weight: _____

How would you rate your child's physical health? Poor Average Good

Does your child have any physical disabilities? Yes No If so, please describe: _____

Does your child have problems sleeping? Yes No

If so, what types of problems? Difficulty falling asleep Wake often Poor Sleep Habits

Other: _____

Has your child experienced any recent changes in his/her appetite? Yes No

Has your child ever had an eating disorder? Yes No

How often does your child exercise? Very Little 1-2 times a week 3-4 times a week Daily

What type(s) of exercise does your child engage in? _____

How would you rate your child's alcohol consumption? None Light Moderate Heavy

Does your child use other recreational or illegal drugs? Yes No

What does your child do for fun or for relaxation? _____

How would you rate your child's social life? Poor Average Good

Please circle items your child experiences:

Anxiety/Nervousness

Shyness

Social Problems

Stress

Anger

Explosive temper

Low Energy

High Energy

Unhappy most of the time

Cry too often

Sadness

Difficulties concentrating/struggles with inattention

Irritability

Impulsivity

Excessive Fears or worries

Trouble making or keeping friends

Trouble picking up on social cues

Problem following directions

Loneliness

Low self confidence

Low self esteem

Excessive Guilt

Poor Study Habits

Fear making mistakes

Thoughts of cutting or burning him/her self

Obsessive thoughts

Unusual thoughts

Hearing or seeing things that others do not hear or see

Body image

Concerns about his/her weight

Sexual problems

Sexual identity

Arguments with significant other(s)

Break up of important relationship

Death of a significant other

Death of a pet

Academic concerns

Financial concerns

Legal concerns

Frequent headaches

Frequent stomachaches

Frequent illness

Family member's psychological problems

Family member's alcohol or drug use

Family members suicide

Does your child ever talk about harming or killing him/her self?

YES NO

Has your child ever attempted suicide?

YES NO

When?

_____

Does your every talk about harming another person?

YES NO

Please describe other health concerns your child has:_____

_____

Current medications your child is taking: _____

Has your child ever been emotionally or physically abused? YES NO If yes, explain:

_____

Has your child ever been sexually abused? YES NO If yes, explain:

_____

_____

DEVELOPMENTAL HISTORY

Please fill in any information you have on the areas listed below.

A. <u>Pregnancy and delivery</u>

1. .Prenatal medical illnesses and health care: _____

2. Was the child premature? _____ Weight and height at birth:_____

Any birth complications or problems? _____

B. <u>The first few months of life</u>

Breast-fed? _____ If so, for how long? _____

Any allergies? _____

Sleep patterns or problems: _____

Personality: _____

_____

C. <u>Milestones: At what age did this child do each of these?</u>

Sat without support:	Crawled:
Walked without holding on:	Helped when being dressed:
Ate with a fork:	Stayed dry all day:
Didn't soil his or her pants:	Stayed dry all night:
Tied shoelaces:	Buttoned buttons:

D. Speech/language development

Age when child said first word understandable to a stranger:

Age when child said first sentence understandable to a stranger:

Any speech, hearing, or language difficulties?

E. Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age Treated	By whom	Consequences

F. Residences

1. Homes

Dates From	To	Location	With whom	Reason for moving	Any problems?

2. Residential placements, institutional placements, or foster care

Dates From	To	Program name or location	Reason for placement	Problems?

G. Schools

School (name, district, address, phone)	Grade	Age	Teacher

May I call and discuss your child with the current teacher? ❑ Yes ❑ No

H. Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences, etc: _____

_____

I. Other

Is there anything else I should know that doesn't appear on this form, but that is or might be important?

_____

_____

_____

Insurance Authorization: I request that payment of authorized insurance company benefits be made on my behalf to New Tampa Psychological Services, Inc. for any services furnished to me or my child by that provider. I authorized any holder of medical information about me or my child to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to/for related services. I understand that my signature requests that payment to the above provider be made and authorized release of medical information necessary to pay the claim.

Parent/Guardian Signature:_____

Date: _____

Name [please print]: _____

The information contained in this self-report was reviewed with the patient.

_____
Tsila Abush-Kirsh, Ph.D.
New Tampa Psychological Services, Inc.

_____
Date