Case No. _____
Referred By _____

New Tampa Psychological Services, Inc.
15310 Amberly Drive, Suite 250, Tampa, FL 33647
TEL: (813) 514-2924
FAX: (813) 600-3574
www.drtsila.com
drtsila@drtsila.com

Adolescent/Young Adult Intake Information Form

PERSONAL INFORMATION

Name: _____ Age: _____ Birthdate: _____

Address: _____

Home Phone Number: _____ Mobile Phone Number: _____

Email Address: _____

Mother's Name: _____

Father's Name: _____

Stepparent's Name(s): _____

Brother/sister/stepbrother/stepsister Name(s) and Age(s): _____

_____

Emergency Contact Information:

Name	Relationship	Phone Number

Do you get along with your parents or stepparents? YES NO Why or why not?

_____

_____

_____

Do you get along with your siblings or stepsiblings? YES NO Why or why not?

_____

_____

_____

Which school do you go to? _____ What grade are you in? _____

How are your grades? Not good Okay Good Very good

What problems do you have in school?

_____

_____

Do you get in fights or get picked on at school or at home? YES NO If yes, please explain:

_____

_____

_____

How many close friends do you have? _____

Do you have a serious relationship now? YES NO

Do you party? YES NO How often? _____

Do you work? YES NO Where? _____

Do you have any hobbies? YES NO What? _____

What makes you happy? _____

_____

What worries or upsets you?

_____

_____

List some of your good qualities (things you like about yourself):

_____

_____

_____

CURRENT HEALTH

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

Height: _____ Weight: _____

How would you rate your physical health? Poor Average Good

Do you have any physical disabilities? Yes No If so, describe: _____

Do you have any specific medical conditions that concern you? Yes No If yes, describe:

_____

_____

Have you received treatment for these conditions? Yes No

Do you have problems sleeping? Yes No

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

Other: _____

Have you experienced any recent changes in your appetite? Yes No

Have you ever had concerns about having an eating disorder? Yes No

How often do you exercise? Very Little 1-2 times a week 3-4 times a week Daily

What type(s) of exercise do you engage in? _____

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

Do you ever consume more than 5 drinks in one setting? Yes No How often? _____

Do you use other recreational or illegal drugs? Yes No

What do you do for fun or for relaxation?

_____

How would you rate your social life? Poor Average Good

Please circle items of concern to you:

Anxiety/Nervousness
Shyness
Social Problems
Stress
Anger
Explosive temper
Low Energy
High Energy
Unhappy most of the time
Cry too often
Sadness
Difficulties concentrating
Loneliness
Low self confidence
Low self esteem
Fear making mistakes

Thoughts of cutting or burning myself
Obsessive thoughts
Unusual thoughts
Unclear Self Image
Excessive Guilt
Study Habits
Employment Issues
Difficulties Trusting Others
Belonging to a minority group
Concerns about my religious beliefs
Daydreaming
Hearing or seeing things that others do not hear or see

Body image
Concerns about my weight
Sexual problems
Sexual identity
Arguments with significant other
Break up of important relationship
Death of a significant other
Death of a pet
Career concerns
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
Do you have thoughts of harming or killing yourself?
YES NO
Have you ever attempted suicide?
YES NO
When?
_____
Do you have thoughts of harming another person?
YES NO

Please describe other health concerns you have:

_____

_____

Current medications you are taking (please print):

_____

_____

_____

COUNSELING INFORMATION

Have you been to counseling before? YES NO When? _____

What for? _____

Did you enjoy it? YES NO Why or why not?

_____

_____

_____

Why do you think you are coming to see me?

_____

_____

_____

If you came to see me for psychotherapy (not testing), what would you like to change in therapy?

_____

_____

_____

What else is important for me to know?

_____

_____

_____

INSURANCE INFORMATION

Only for Clients who are 18 y/o or older, please provide the following 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/Slate/Zip	I.D. #:
Claims Phone #:	Group #:

Thank you for answering these questions.

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.

Signature: _____ Today's Date: _____

Name [Please print]:_____

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

_____ _____

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

This is a strictly confidential patient medical record. Disclosure or transfer is expressly prohibited by law.