**Intake** **Today's date:_______________**

This questionnaire will help your therapist understand your situation. If you feel uncomfortable answering any of the questions, you may leave them blank and discuss them when you meet with your therapist.

Client's Name:___________________________________________________
First Middle Initial Last

Home Address:___________________________________________________
Street Address City State Zip Code

Phone: (Home) ____________________ (Cell) _______________________
(Ok to text circle Y or N)
Please circle preferred method of contact (home or cell)

**Emergency Contact:**
(Name)__________________________________________________________

(Phone) ______________________ (Relationship) _________________________

**Insurance Information:**

Primary Insurance Company: ______________________________________

Member ID: ________________________________ Copay: _____________

Secondary Insurance Company: ____________________________________

Member ID: ________________________________ Copay: _____________

**Referred By**: _______________________________________________________

**Personal Information:**
1. Age: ______ 2. Date of birth: _____________ 3. Gender ________

4. Social Security#: ___________________

5. Ethnicity (circle all that apply):
Caucasian Black/African-American Asian
Hispanic Native American Other: ____________________

6. Religious background (circle one)
Protestant Catholic Jewish No affiliation Other: _______________

**Family History**:
7. The name of the child's biological parents:

Mother: ___________________________ Father: _________________________

Who has legal guardianship of your child? ______________________________

8. Names of other household members living with your child and their relationship.

| Name | Gender (M/F) | Age | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Family/Social History**

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to the child in the space provided (father, grandmother, uncle, etc.).

| | Please Circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | ____________________ |
| Anxiety | yes/no | ____________________ |
| Depression | yes/no | ____________________ |
| Domestic Violence | yes/no | ____________________ |
| Eating Disorders | yes/no | ____________________ |
| Neurological condition | yes/no | ____________________ |
| Obesity | yes/no | ____________________ |
| Obsessive Compulsive Behavior | yes/no | ____________________ |
| Panic attacks | yes/no | ____________________ |
| Phobias | yes/no | ____________________ |
| Schizophrenia | yes/no | ____________________ |
| Suicide Attempts | yes/no | ____________________ |

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**Education History**

1. What school does your child attend? ______________________________________
   Address: ______________________________________________________________
   Phone: __________________________ Teacher's Name: ______________________
   Current Grade: ______________

2. What does your child's teacher say about him/her?

   ___________________________________________________________________________
   ___________________________________________________________________________
   ___________________________________________________________________________

3. Other schools attended (including pre-school):

   ___________________________________________________________________________
   ___________________________________________________________________________
   ___________________________________________________________________________

4. Has your child ever repeated a grade? If so which one(s)?

   ___________________________________________________________________________
   ___________________________________________________________________________
   ___________________________________________________________________________

5. Has your child ever received special education services?

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

6. Has your child experienced any of the following problems at School? (Circle)

| | | |
|---|---|---|
| Fighting | Lack of friends | Drug/Alcohol |
| Detention | Suspension | Learning Disabilities |
| Poor attendance | Poor grades | Bullying |
| Gang influence | Incomplete homework | Behavior problems |

**Medical History**

1. What is the name of your child's primary care physician? ________________________
   Address: ______________________________________ Phone: _______________

   Date of your child's last medical examination: _____________________________

2. Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

3. Has your child experienced any of the following medical problems? (circle)

| | | | |
|---|---|---|---|
| A serious accident | Hospitalization | Surgery | Asthma |
| A head injury | High fever | Convulsions/seizures | |
| Eye/ear problems | Meningitis | Hearing problems | |
| Allergies | Loss of consciousness | | Other:______________ |

4. Please list any current medical problems or physical handicaps:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

5. Please list any medications your child takes on a regular basis:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

**Current Problems and Treatment History:**

1. Has your child ever experienced any type of abuse (physical, sexual, or verbal?
2. Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?
3. Has he/she ever purposely hurt himself or another?
4. If yes to either of the above question please describe the situation:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

5. Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

6. Finally, what are some of the things that are currently stressful to your child and his/her family? When did they start?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Other Background:**

1. Has your child ever been involved in a lawsuit? CPS complaint?

If yes, please describe the circumstances and give dates:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

2. Is there any other information that would be helpful for me to know? Yes/No

If yes, please explain:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________