Working Together

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New Client (Child) Intake Form

CHILD INFORMATION

Client's First Name	Middle Name	Last Name

Is this your legal name? ! Yes ! No	If not, what is your legal name?	Birth Date	Age	Sex !M !F

Street Address	City	State	ZIP Code	Parent/Guardian Social Security - -	Home Phone No. ( )

Parent/Legal Guardian First Name	Middle Name	Last Name	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ! Dr. _____ ! Insurance Plan ! Website

! Family ! Friend ! Close to Home/Work ! Yellow Pages ! Other _____

Email Address:	Is it okay to say Mike Jahn when calling or leaving messages? ! Yes ! No

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered.

X _____ CLIENT/GUARDIAN SIGNATURE*

_____DATE

**If client is under 18 years old, signature of Legal Guardian is required.*

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible for any balance due prior to a decision to stop.

X _____ CLIENT/GUARDIAN SIGNATURE*

_____DATE

**If client is under 18 years old, signature of Legal Guardian is required.*

CLIENT INFORMATION

MEDICAL HISTORY

Name of Primary Care Physician: _____ Physician's Phone: _____

Current medications being taken:

1)_____ Dosage/Freq_____Start Date_____Purpose_____

2)_____ Dosage/Freq_____Start Date_____Purpose_____

3)_____ Dosage/Freq_____Start Date_____Purpose_____

4)_____ Dosage/Freq_____Start Date_____Purpose_____

Prescribed by:_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience:

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain:

What was the last year of school you completed? _____ If you did not complete high school, please explain:

(1) How would you describe your current support network? (friends, relatives, etc.): _____

Please check all information which applies to your biological parents:

MOTHER
____living
____ deceased
____ married
____ divorced
____ remarried____# of times

FATHER____living
____deceased
____married
____divorced
____remarried____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

Describe your relationship with your mother:

Describe your relationship with your father:

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse:

Sexual/physical/emotional abuse:

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

____sad_____anxious_____depressed_____frightened_____guilty_____angry_____ashamed_____aggressive____resentful

____worthless____tearful_____irritable_____confused_____extreme ups/downs_____jealous_____hopeless_____helpless

Describe any other feelings you have had:

What activities or hobbies do you participate in?

Do you exercise? (Circle One) YES NO

Describe:

Describe your current working environment:

Have you had any change in sleeping habits? (Circle One) YES NO

Describe:

Have you had any change in eating habits? (Circle One) YES NO Describe:

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain:

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain:

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.)

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.

_____I sometimes feel that forces outside of me control me.

_____I sometimes feel that other people control my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes feel that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior. Please explain:

Family Members Living in the Home

Name	Age	Relationship (father, mother, sibling, step, etc.)

Is there any other information regarding you or your family that you would like to share with your therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

THANK YOU!