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INTAKE FORM

Name: ______________________ Date of Birth: ______

Phone number: ___________________
Emergency Contact name and phone: ____
Address: ____

Family Constellation: List name & relationship of family members residing with you (i.e., Sue, Mother). Please list them in rank order in terms of family leadership. Then rate (1-10 with 1 being low, 10 being high) their relationship with you (or your minor child).

_________________________________Age: ____; Closeness = _____(1-10) Conflict = _____ (1-10)
_________________________________Age: ____: Closeness = _____ Conflict = _____
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_________________________________Age: ____; Closeness = _____ Conflict = _____
_________________________________Age: ____; Closeness = _____ Conflict = _____
_________________________________ Age: ____; Closeness = _____ Conflict = _____
_________________________________ Age: ____; Closeness = _____ Conflict = _____
Others living in the home: ____

What is the main concern that brought you in? ____
____
____
____

When did the problem start? ____

Can you recall any life circumstances or changes that occurred around the time the problem(s) started?
____
____

What solutions have been attempted (i.e., relationship changes, professional help)? When is the problem better (i.e., time of day, when rested)? What unique strengths do you (and your child) bring to bear on the problem?
____
____
____
____

Treatment History: Have you (child) received previous counseling or been tested? ___Yes ___ No

Name(s)	Address/phone	Dates of Service

Describe the effectiveness of these services and your satisfaction with them: ______________________
____
____

Have you (or child) been hospitalized for psychological/psychiatric reasons? ____ Yes____ No

Hospital(s)	Address	Dates of Hospitalization
________________	______________________	______________
________________	______________________	______________
________________	______________________	______________

Family Psychiatric History: Please indicate which of the following is true for yourself or any other family members:

	Self	Mother	Father	Sibling	Grand parent	Uncle	Aunt
Depression	____	____	____	____	____	____	____
Anxiety	____	____	____	____	____	____	____
Bipolar disorder (i.e., mania)	____	____	____	____	____	____	____
Suicide Attempts	____	____	____	____	____	____	____
Thought disorder (i.e., schizophrenia)	____	____	____	____	____	____	____
Drug or Alcohol Problem	____	____	____	____	____	____	____
Other Mental/Emotional Problems	____	____	____	____	____	____	____

MEDICAL HISTORY: If your (child's) medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

___ Childhood diseases ____
___ Operations ____
___ Hospitalizations for illness(es) other than operations ______________________________
___ Head Injuries ____Unconscious? ____
___ Convulsions ____
___ Prolonged Fever ____
___ Meningitis or encephalitis ____
___ Immunization reactions ____
___ Eye problems ____
___ Ear Problems ____

Your overall rating of your health: Good ___ Moderate ___ Poor ___ Date of last exam? __________

Name/Address/phone of Physician: ____

Present illness(es) you are being treated for: ____________________________________

Medications you are taking on an ongoing basis: ___________________________________

____
Client/Guardian Signature Date

____

David Pincus, Ph.D. Date