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PSYCHOSOCIAL INTAKE FORM

SECTION 1: IDENTIFYING INFORMATION

Child's Name: _____ Date of Birth: _____ Age Today: _____

Home Address: _____

Best Phone # to reach child (if adolescent): _____

Parent/Legal Guardian Names: _____ *(1st Parent)*

_____ *(2nd Parent)*

If other than parent, relationship to child: _____

Parents/Legal Guardian Contact Information:

Primary Phone(s): *(1st Parent)* _____ *(2nd Parent)* _____

Work Phone(s): *(1st Parent)* _____ *(2nd Parent)* _____

Email address(es): *(1st Parent)* _____ *(2nd Parent)* _____

Occupation(s): *(1st Parent)* _____ *(2nd Parent)* _____

If Child resides in two households, please provide the 2nd address:

_____

_____

SECTION 2: EMERGENCY INFORMATION

If some kind of emergency arises and we cannot reach you directly, whom should we call?

Name: _____ Relationship: _____

Address: _____ Phone: _____

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Section 3: Medical & Mental Health Information

Primary Care Physician

Name: _____ Phone: _____

Date of Last Visit: _____ Current Health Problems: Y / N *(circle one)*

If yes, please describe:

_____

_____

Psychiatric Care

Is child ***currently*** seeing a psychiatrist?*:* Y / N *(circle one)*

If yes, name: _____ Phone _____

Current Psychiatric Diagnosis if known:_____

Has child ever been hospitalized for psychiatric problems: Y / N *(circle one)*

Psychologists/Other Therapists.

Is child ***currently*** seeing another therapist: Y / N *(circle one)*

Name of ***current and previous*** therapists and dates of service *(use reverse if necessary)*:

Name(s)	**Dates**
_____	From_____ To_____
_____	From_____ To_____

Section 4: Family Information

Parents/Guardians:

Relationship Status *(circle one)*: Single Married Separated Divorced Widowed Cohabitating

If parents are divorced, who currently has legal custody?: _____

If married, # of years: _____ If Divorced, # of years: _____ If remarried, # of years: _____

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Any family history of mental health or substance abuse issues (including extended family)? Y / N *(circle one)*

If yes, please describe: _____

_____

_____

Please List Child's Siblings *(use reverse if necessary)*:

	Name	Age	Gender		Lives At Home?		
			Female	*Male*	*Yes*	*No*	*Sometimes*
1							
2							
3							

Have any siblings exhibited behavioral issues in the past or present: Y / N *(circle one)*

If yes, please describe: _____

_____

_____

Section 5: School Information

Current School: _____ Phone: _____

Grade Level: _____ Teacher(s): _____ Teacher's Phone: _____

Type of School *(circle one)*:

Public Charter/Magnet Private/Parochial Home Alternative /Therapeutic

On Average, what types of grades is your child earning *(circle one)*:

A's – B's B's – C's C's – D's D's – F's Not Applicable

Active IEP (Individualized Education Program) or 504 Plan? Y / N *(circle one)*

If yes, please describe: _____

_____

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Section 6: Developmental History

	Within Normal Limits? *(circle Y/N)*	**Concerns/Issues?** *(describe specific concern or issue)*
Early Childhood (i.e., prenatal care, delivery complications, separation anxiety, life events; Milestones — walk, talk, toileting)	**Yes** **No**	
Middle Childhood (*if applies*) (i.e., significant life events, problems with peers/siblings, age appropriate behavior, school problems; skip/retain grade)	**Yes** **No**	
Adolescence (*if applies*) (i.e., significant life events, sexuality or gender issues, truancy, illegal behavior, substance use)	**Yes** **No**	
Cognitive Functioning (i.e., developmental delay, learning disability, making academic progress)	**Yes** **No**	
Sensory Functioning (i.e., visual or auditory problems, tactile issues)	**Yes** **No**	
Fine and Gross Motor Skills (i.e., motor problems, writing challenges, motor delays)	**Yes** **No**	

Section 7: Social Functioning

Please describe your child's strengths and resources in each of the following areas:

Interpersonal: _____

Creative: _____

Academic: _____

Athletic: _____

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Please describe your child's friendships, and note any concerns: _____

_____

_____

Has your child experienced changes, undo stress, or trauma in the past year? Y / N *(circle one)*

If yes, please describe: _____

_____

_____

Are there any relevant cultural factors that impact your child's current functioning or treatment (i.e., religious affiliation and traditions, acculturation issues, alternative healing practices)?

If yes, please describe: _____

_____

_____

Section 8: Current Presenting Issues

Please briefly describe any reasons for seeking therapy at this time:

_____

_____

_____

What other relevant information (i.e., concerns, recent events, stressors) would you like me to know?

_____

_____

_____

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DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes	❑ No	❑ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes	❑ No	❑ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	❑ Yes	❑ No	❑ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or steroids)?	❑ Yes	❑ No	❑ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	❑ Yes	❑ No	❑ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	❑ Yes	❑ No	❑ Don't Know			