

## Psychology Intake Form

What led you to seek psychological services for your child and/or family?

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Has your child ever been evaluated or treated by a psychologist or psychiatrist in the past?  Yes  No

If yes, when and for what reason(s)? \_\_\_\_\_  
 \_\_\_\_\_

**Indicate which stressors your child is experiencing now (within last 6 months) or has in the past:**

- | Now                      | Past                     |                         | Now                      | Past                     |                          | Now                      | Past                     |                        |
|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Death of family member  | <input type="checkbox"/> | <input type="checkbox"/> | Illness of family member | <input type="checkbox"/> | <input type="checkbox"/> | Illness of friend      |
| <input type="checkbox"/> | <input type="checkbox"/> | Personal injury/illness | <input type="checkbox"/> | <input type="checkbox"/> | Parents separated        | <input type="checkbox"/> | <input type="checkbox"/> | Parents divorced       |
| <input type="checkbox"/> | <input type="checkbox"/> | Conflicts within family | <input type="checkbox"/> | <input type="checkbox"/> | Conflicts with friends   | <input type="checkbox"/> | <input type="checkbox"/> | Conflicts at school    |
| <input type="checkbox"/> | <input type="checkbox"/> | Academic difficulties   | <input type="checkbox"/> | <input type="checkbox"/> | Change in residence      | <input type="checkbox"/> | <input type="checkbox"/> | Legal problems         |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual abuse            | <input type="checkbox"/> | <input type="checkbox"/> | Physical abuse           | <input type="checkbox"/> | <input type="checkbox"/> | Verbal/emotional abuse |

Other Concerns: \_\_\_\_\_

Please check all that apply to your child:

- |   |  |
|---|--|
| <input type="checkbox"/> Suicidal thoughts                                      | <input type="checkbox"/> Fatigue                                   |
| <input type="checkbox"/> Depression/sadness                                     | <input type="checkbox"/> Rapid mood changes                        |
| <input type="checkbox"/> Anxiety/nervousness                                    | <input type="checkbox"/> Loss of interest in almost all activities |
| <input type="checkbox"/> Recurrent/intrusive thoughts                           | <input type="checkbox"/> Feeling worthless                         |
| <input type="checkbox"/> Nightmares   | <input type="checkbox"/> Racing thoughts                           |
| <input type="checkbox"/> Academic difficulties                                  | <input type="checkbox"/> Feelings of hopelessness                  |
| <input type="checkbox"/> Loss of appetite or over-eating                        | <input type="checkbox"/> Decreased need for sleep                  |
| <input type="checkbox"/> Weight loss or gain                                    | <input type="checkbox"/> Poor self esteem                          |
| <input type="checkbox"/> Recurrent/intrusive disturbing recollections or dreams | <input type="checkbox"/> Aggressive                                |
| <input type="checkbox"/> Overwhelming need to perform certain behaviors/rituals | <input type="checkbox"/> Visual or auditory hallucinations         |
| <input type="checkbox"/> Excessive fears or phobias                             | <input type="checkbox"/> Stomach aches                             |
| <input type="checkbox"/> Significant concerns with physical problems            | <input type="checkbox"/> Unmotivated                               |
| <input type="checkbox"/> Difficulty sleeping                                    | <input type="checkbox"/> Bizarre behavior                          |
| <input type="checkbox"/> Poor frustration tolerance                             | <input type="checkbox"/> Overly dependent                          |
| <input type="checkbox"/> Explosive anger  | <input type="checkbox"/> Shy and withdrawn                         |
|   | <input type="checkbox"/> Quiet                                     |

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|---|--|
| <input type="checkbox"/> Harms self on purpose                            | <input type="checkbox"/> Rarely follows other's instructions |
| <input type="checkbox"/> Resists change                                   | <input type="checkbox"/> Easily lies to others               |
| <input type="checkbox"/> Self-stimulates                                  | <input type="checkbox"/> Steals things                       |
| <input type="checkbox"/> Wetting bed or clothes                           | <input type="checkbox"/> Destroys other people's property    |
| <input type="checkbox"/> Exhibits sexually inappropriate behavior         | <input type="checkbox"/> Irritable                           |
| <input type="checkbox"/> Picks at skin or pulls out hair                  | <input type="checkbox"/> Is cruel to animals                 |
| <input type="checkbox"/> Overly emotional                                 | <input type="checkbox"/> Starts fights with others           |
| <input type="checkbox"/> Immature for age                                 | <input type="checkbox"/> Homicidal thoughts                  |
| <input type="checkbox"/> Is very fidgety                                  | <input type="checkbox"/> Other unusual behavior:             |
| <input type="checkbox"/> Can't remain seated                              | _____  |
| <input type="checkbox"/> Can't wait his/her turn when playing with others |  |
| <input type="checkbox"/> Answers before s/he hears the whole question     |  |

What are your goals for evaluation and/or therapy?

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What are 3 positive qualities about your child?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_