9915 E. Bell Rd., Suite 120, Scottsdale, AZ 85260

INTAKE INFORMATION

Date: ________________ Referred by: Self Doctor Friend Family member Other

Child's Name ____

Date of Birth ________________ Age ________________

Address ____

City ________________ State ________________ Zip ________________

Home Phone ________________ Cell Phone ________________ Email ________________

Is it okay to leave a message? Home: Yes / No Cell: Yes / No

Name of other Parent (if applicable) ____________________________ Phone ________________

Name of Step-Parent (if applicable) ____________________________ Phone ________________

Emergency Contact (if not above) ____________________________ Phone ________________

Name of School ____________________________ Grade ________________

School Counselor (if applicable) ____________________________ Phone ________________

Primary Care Physician ____________________________ Phone ________________

Psychiatrist (if applicable) ____________________________ Phone ________________

Other Service Provider ____________________________ Phone ________________

Areas of concern that you have for your child (or yourself as parent). Please check all that apply.

Identity		Physical Health		Emotional Health		Behaviors	
Family Relationships		Social		School/Educational		Developmental	
Parenting		Adjustment/Life Changes		Traumatic event(s)		Body Image	
Grief/Loss		Stress		Cultural/Spiritual		Other	

Please place an X next to any of the following which apply to your child. If you are unsure but think and item MAY apply, place a question mark (?) in the box. Write a brief explanation, as you perceive it, next to any marked box
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	Alcohol use			Lying	
	Anxious			Mood swings	
	Bedwetting			Nail biting	
	Competitive, overly			Nervousness	
	Crying, excessively			Phobia(s)	
	Daydreams			Power Struggles	
	Demanding			Rebelliousness	
	Depressed			Running away	
	Destructive			School adjustment	
	Disorganized			School truancy	
	Drug use			Self harm	
	Easily Distracted			Sensitive to criticism	
	Eating Concerns			Sexual Activity	
	Feels unloved			Sexual orientation	
	Fighting excessively			Shyness	
	Fire setting			Sleeping	
	Harm to animals			Stealing/theft	
	Head banging			Stuttering	
	Hyperactivity			Suicidal threats/attempts	
	Impulsive			Temper tantrums	
	Learning disabilities			Verbally aggressive	
	Loner (isolates)			Violent behavior	

What difficulties are you/your child currently experiencing?

____

____

____

____

How long have these difficulties been a concern?

____

____

How do these difficulties affect you and your family?

____

____

____

Are you receiving help for these difficulties anywhere else? Where? Is it helpful?

____

____

____

What do you hope to accomplish by participating in counseling? How will you know if you and your child are making progress?

____

____

____

Have you or anyone else in your family received counseling in the past? When? Was it for related or different difficulties? Was it helpful?

____

____

____

Is there anyone not present today that you would like included in future counseling sessions?

____

____

____

Family and Home Information

Parent(s) Marital Status: Single / Married / Live Together / Divorced / Widowed

If parents are divorced, what is the date of divorce (month, year)? ____

**Please note, consent for therapy is required of both parents if parents are divorced and both have legal custody. Participation in an initial parent session is encouraged for both parents, but is not required.

Parent(s) occupation(s) Mother: __________________________   Father:____________________________

What are the names and ages of all people living in your home? What is his/her relationship to the client?

Are there any other immediate family members who don't live with you?

Are there any aspects of your home/living environment with which you are dissatisfied?

Health Information

Does your child have any medical conditions or health problems? If so, is he/she receiving treatment?

Please list any medications your child is currently taking.

Please list any psychiatric medications that your child has taken in the past. Where they helpful?

Has your child ever been hospitalized for psychiatric treatment? If so, when and where was he/she hospitalized?

Please list any immediate or extended family members who have had mental illness or substance abuse issues.

Has your child ever attempted suicide? If yes, please provide details.

Do you believe your child currently drinks alcohol? Approximately how many drinks per week?

Do you believe your child currently uses recreational drugs? How often?

Social, Spiritual and Cultural Information

Who are your child's primary supports in life? Please include both formal (e.g., groups, team) and informal (e.g., friends, family).

Is there any information you would like to share regarding your child's cultural background ?

Is there any information you would like to share regarding your child's spiritual/religious beliefs and practices or any other significant aspects of his/her life?