Professional Psychological Services

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INTAKE FORM - MINOR

Name:_____
Last First Middle Initial

Date of Birth: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female
MM DD YY

Name of Parent(s)/Legal Guardian(s): _____

Address: _____
Street and Number

_____
City State Zip

Home Phone: (_____) _____ May we leave a message? ☐ Yes ☐ No

Cell Phone: (_____) _____ May we leave a message? ☐ Yes ☐ No

Email: _____ May we email you? ☐ Yes ☐ No

Phone of Minor (if applicable): (_____) _____ May we leave a message? ☐ Yes ☐ No

Preferred method of contact: _____

Referred by: _____

Referred by: _____

Name of school and current grade: _____

Are you failing any classes?

☐ No

☐ Yes, please explain: _____

_____

Have you ever been suspended or expelled from school?

☐ No

☐ Yes, please explain:_____

General Health and Mental Health Information

How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any health problems you are currently experiencing: _____

_____

Are you currently taking any prescription medication?

☐ No

☐ Yes, please list: _____

_____

Have you ever been prescribed psychiatric medications?

☐ No

☐ Yes, please list and provide dates: _____

_____

Have you previously received any type of mental health services including psychological testing?

☐ No

☐ Yes, previous provider and reason: _____

_____

Do you use: ☐ Alcohol ☐ Drugs ☐ No alcohol/drug history

Have you been treated for alcohol/drug problems before?

☐ No

☐ Yes, previous provider and dates: _____

_____

What brings you in for services and what would you like to accomplish?

_____

_____

_____

_____

Please check any of the following that you have experienced recently:

- ☐ Depression
- ☐ Suicide Ideation
- ☐ Appetite problems
- ☐ Weight loss/gain
- ☐ Poor attention
- ☐ Distractibility
- ☐ Aggression/violence
- ☐ Hyperactivity
- ☐ Other(s)

_____

- ☐ Anxiety
- ☐ Panic attacks
- ☐ Sleep problems
- ☐ Racing thoughts
- ☐ Anger
- ☐ Irritability
- ☐ Poor concentration
- ☐ Memory problems

- ☐ Voices/visions
- ☐ Paranoia
- ☐ Compulsive behaviors
- ☐ Too much energy
- ☐ Social withdrawal
- ☐ Low energy
- ☐ Blackouts

Family Mental Health History

In the section below, please circle yes or no if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (example: mother, father, cousin, etc.).

	Please Circle	List Family Member(s)
Alcohol/Drug Use	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Bipolar Disorder	Yes / No	
Post-traumatic Stress	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempt(s)	Yes / No	
Eating Disorder	Yes / No	
Violence	Yes / No	
Other:		

_____ _____

Printed name of client Date

_____ _____

Signature of parent/legal guardian Date