Psychological HealthCare, P.L.L.C

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600 East Genesee Street Ste 217
Syracuse, NY 13202
315-422-0300
Fax: 315-479-8455

890 Seventh North Street, Suite 200
Liverpool, NY 13088
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Radisson/Baldwinsville
8289 Loop Road
Baldwinsville, NY 13027
315-638-2853
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Child Intake Information Form

(For adolescents over the age of 12)

THIS PAGE TO BE FILLED OUT BY PARENT/GUARDIAN.

Today's date: ________________________________

Client name: ________________________________ Date of Birth: _________ Age: _________ SS#: _________________

Name of Parent/Guardian completing this page: ____

Parent/Guardian Home Address: ____ City: ________________ Zip: ___

If your clinician needs to contact you, please indicate where you prefer to be called (Please check all that apply):

Home Phone #: _______________ Work Phone #: _______________ Cell Phone #: _________

Email Address: ____ By Mail to My Home Address

In the event of an emergency, whom should we contact?

(1) Name: ____ Phone #: ____________________________

Relationship to client: _______________________________________

(2) If you **do not wish us to contact** anyone you know in the event of an emergency check here:

Client Racial/Ethnic Identity of Client (Optional): ________________________________ Marital Status: ________________

Is client currently in school: yes no Current Grade: _____________
Name of School: ____ Name of School District: ______________________
Name and # of School Contact: _______________________________________ CSE Classification (if any): _____________

From whom or where does your child get his or her primary medical care?

Clinical/Doctor's name: ____ Phone: ______________________________
Address:
____
____

Referral: Who gave you my name to call? If it was your child's primary doctor listed above, leave blank
Name: ____ Phone: ________________________________
Address: ____

What is the presenting problem as you, the parent/guardian see as the reason for your visit today?
____
____
____
____

Remainder of Packet filled by adolescent client.

Your name: ____

Please describe the main difficulty that has brought you to see me:

Have you ever received psychological, psychiatric or counseling services before?
No Yes If yes, please indicate:

When?	From whom?	For What?	With what results?

Have you ever taken medications for psychiatric or emotional problems? No Yes
If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?

Have you ever been hospitalized or removed from the home due to psychiatric or emotional problems? No Yes If yes, please indicate:

When?	Where?	For What?	With what results?

Please describe the following:

1. Your relationship with your parents or other adults in the home:

2. Your relationship with your brothers and sisters:

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Your name: ________________________________

3. Your performance in school:

____
____
____
____

4. Your relationship with friends:

____
____
____
____

Abuse history: I was not abused in any way. I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, as in touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?
______	____________	____________	________________	______________	____________
______	____________	____________	________________	______________	____________
______	____________	____________	________________	______________	____________

Substance use:

1. Have you ever felt the need to cut down on your drinking? No Yes
2. Have you ever felt annoyed by criticism of your drinking? No Yes
3. Have you ever felt guilty about your drinking? No Yes

How much beer, wine, or hard liquor do you consume each week, on average?

____
____

4. How much tobacco do you smoke or chew each week? ____________________________________

Which drugs (not medications prescribed for you) have you used in the last few years?

____
____
____

Which of these have you had?

Blackouts Bad reactions Withdrawal symptoms Overdoses
Detoxification in a hospital Other problems due to substance abuse
None of these

Do you have an allergy to any medicines?
No Yes If yes, which medicines? ____

Do you have any other allergies?
No Yes If yes, what kind of allergies? ____

Do you have any current physical illness or medical problem?
No Yes If yes, please describe:

____

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Your name: ________________________________

Have you ever been hospitalized due to serious injury?
No Yes If yes, please describe:

____
____
____

Are any other agencies or providers not listed above involved with your family at this time?

No Yes If yes, please list relevant names and phone numbers:

____
____

Do you have a legal/criminal history?
No Yes If yes, please describe:

____
____
____

Are you sexually active? No Yes

Other
Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here:

____
____
____
____
____
____
____

This is a strictly confidential client medical record. Redisclosure or transfer is expressly prohibited by law.