

Psychological HealthCare, P.L.L.C

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315-422-0300
Fax: 315-479-8455

890 Seventh North Street, Suite 200
Liverpool, NY 13088
315-200-1056
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3300 James Street
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Radisson/Baldwinsville
8289 Loop Road
Baldwinsville, NY 13027
315-638-2853
Fax: 315-638-3145

Child Intake Information Form

(For Children under the age of 12)

Entire packet 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 Telephone #: _____ Work Telephone #: _____ Cell Phone #: _____

Email Address: _____ By Mail to My Home Address

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

(1) Name: _____ Telephone: _____

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): _____

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: _____

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Client Name: _____

Please describe the main difficulty your child is having that has brought you to see me:

Has your child or family ever received psychological, psychiatric or counseling services before? No Yes If yes, please indicate:

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

Has your child ever taken medications for psychiatric or emotional problems?

No Yes If yes, please indicate:

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

Has your child 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 child's relationship with you or other adults in the home: _____

2. Your child's relationship with brothers and sisters: _____

3. Your child's performance in school: _____

4. Your child's relationship with friends:

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Your child's name: _____

Abuse history: My child was not abused in any way. My child was abused. If your child was 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 be protected. E = Emotional, such as humiliation, etc.

Child's Kind of Consequences

age abuse By whom? Effects on child? Whom did your child tell? of telling?

Does your child have an allergy to any medicines?

No Yes If yes, which medicines? _____

Does your child have any other allergies?

No Yes If yes, what kind of allergies? _____

Does your child have any current physical illness or medical problem or a history of such? No Yes If yes, please describe:

Has your child ever been hospitalized due to serious injury?

No Yes If yes, please describe: _____

Do you suspect that your child has experimented with or is currently using drugs or alcohol? 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: _____

Other

Is there anything else that is important for me as the 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. Rediscovery or transfer is expressly prohibited by law.