Clinical Psychology
PSY24899
REBECCA WURZBURGER, PSYD

ADOLESCENT INFORMATION - INTAKE FORM

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session

PARENT'S NAME: _____ MALE/FEMALE: _____

NAME PREFERRED TO BE CALLED: _____

DATE OF BIRTH and PLACE OF BIRTH: _____ AGE: _____

ADDRESS: _____

TELEPHONES: Home: _____ Cell: _____

Work: _____ Email: _____

CONFIDENTIAL/PRIVATE MESSAGES CAN BE LEFT AT: Phone: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

OCCUPATION: _____

PARENT'S NAME: _____ MALE/FEMALE: _____

NAME PREFERRED TO BE CALLED: _____

DATE OF BIRTH and PLACE OF BIRTH: _____ AGE: _____

ADDRESS: _____

TELEPHONES: Home: _____ Cell: _____

Work: _____ Email: _____

CONFIDENTIAL/PRIVATE MESSAGES CAN BE LEFT AT: Phone: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

OCCUPATION: _____

CHILD'S NAME: _____ MALE/FEMALE: _____

NAME CHILD PREFERS TO BE CALLED: _____

DATE OF BIRTH and PLACE OF BIRTH: _____ AGE: _____

SCHOOL: _____ GRADE: _____

PEDIATRICIAN and PHONE NUMBER: _____

CHILD LIVES WITH: _____

PERSON & PHONE NO. TO CALL IN EMERGENCY: _____

REFERRAL SOURCE: _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you.):

_____

_____

_____

_____

Estimate the severity of above problem: Mild _____ Moderate _____ Severe _____ Very severe ____

CHILD'S SIBLINGS (name/age and brief statement about the relationship.):

1. _____
2. _____
3. _____

PAST/PRESENT MEDICAL CARE OF CHILD (major medical problems, surgeries, accidents, falls, illness, etc.):

_____

_____

_____

_____

SPECIFY MEDICATION CHILD is presently taking and for what. PRINT clearly:

_____

_____

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE CHILD AND/OR PARENT (AA, NA, treatments):

_____

_____

_____

SUICIDE ATTEMPT/S OF CHILD AND/OR PARENT (describe ages, reasons, circumstances, how etc.)

VIOLENT BEHAVIOR OF CHILD AND/OR PARENT (describe: ages, reasons, circumstances, how, etc.)

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc):

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

PAST/PRESENT PSYCHOTHERAPY (specify: month year(s) (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.

DESCRIBE YOUR CHILD'S CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, major life stressors, moves, deaths, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

(use the back of the page if you need more space)

ESTIMATE HOW MANY HOURS/DAY YOU OR YOUR CHILD SPENDS ONLINE (Facebook, YouTube, internet gaming, browsing, etc.):

Facebook: _____YouTube: _____ Gaming: _____ Browsing: _____ Other: _____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

What do you believe gives your child the most joy or pleasure in life?

What are your main worries and fears? What are your child's main worries and fears?

Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.

Please circle the symptoms that your child is currently experiencing (if any):

SYMPTOMS:	NONE	MILD	MODERATE	SEVERE	FOR HOW LONG
Sadness/Depression	0	1	2	3	
Hopelessness	0	1	2	3	
Suicidal Thoughts	0	1	2	3	
Sleep Problems	0	1	2	3	
Change in Appetite	0	1	2	3	
Weight Change	0	1	2	3	
Bedwetting	0	1	2	3	
Stomach Aches	0	1	2	3	
Head Aches	0	1	2	3	
Inability to Concentrate	0	1	2	3	
Obsessive Thoughts	0	1	2	3	
Tension/Anxiety	0	1	2	3	
Panic Attacks	0	1	2	3	
Memory Problems	0	1	2	3	
Compulsive Behaviors	0	1	2	3	
Hostility/Anger	0	1	2	3	
Acts of Violence	0	1	2	3	
Social Isolation	0	1	2	3	
Strange Thoughts	0	1	2	3	
Phobias	0	1	2	3	
Other					

Please circle the symptoms that either of the parents are currently experiencing (if any) and indicate which parent:

SYMPTOMS:	NONE	MILD	MODERATE	SEVERE	FOR HOW LONG
Sadness/Depression	0	1	2	3	
Hopelessness	0	1	2	3	
Suicidal Thoughts	0	1	2	3	
Sleep Problems	0	1	2	3	
Change in Appetite	0	1	2	3	
Weight Change	0	1	2	3	
Inability to Concentrate	0	1	2	3	
Obsessive Thoughts	0	1	2	3	
Tension/Anxiety	0	1	2	3	
Panic Attacks	0	1	2	3	
Memory Problems	0	1	2	3	
Compulsive Behaviors	0	1	2	3	
Hostility/Anger	0	1	2	3	
Acts of Violence	0	1	2	3	
Social Isolation	0	1	2	3	
Strange Thoughts	0	1	2	3	
Sexual Problems	0	1	2	3	
Phobias	0	1	2	3	
Other					

PLEASE ADD ANY ADDITIONAL INFORMATION THAT YOU WOULD LIKE ME TO KNOW: