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EVALUATION INTAKE FORM

DEMOGRAPHIC INFORMATION

Name _____ Intake Date _____/_____/_____

Date of Birth _____/_____/_____ Age _____ Gender Identity _____

Social Security Number _____-_____-_____ Relationship Status _____

Street Address _____ City/State/Zip _____

Primary Phone (_____) _____-_____ OK to leave message? _____

Secondary Phone (_____) _____-_____ OK to leave message? _____

Email _____ OK to contact via email? _____

Preferred method(s) of contact: ____ Phone ____ Email

Ethnic/Racial Identity _____ Sexual Orientation _____

Occupation _____ Employer/School _____

Spiritual Orientation _____ Referred by _____

CURRENT HEALTH AND MEDICAL CARE

Please address the following regarding your general physical health:

Medical diagnoses _____

_____

Allergies _____

How would you describe your eating habits? _____

_____

How many meals/snacks do you eat per day? _____

Any dietary restrictions? Yes No If yes, what? _____

How would you describe your sleeping habits? _____

_____

How many hours of sleep do you get on average per night? _____

Do you experience nightmares or night terrors? Yes No If yes, how often? _____

Any difficulties falling or staying asleep? Yes No Early awakening? Yes No

Do you exercise? Yes No If yes, how often? _____

What type of exercise/physical activity do you do? _____

Average daily caffeine use _____ Average daily nicotine use _____

Average weekly alcohol consumption _____ Use any other drugs? Yes No

If yes, what and how often?_____

If you are currently taking medication, please indicate the type, dosages, and prescriber:

_____	_____	_____
Medication	Dosage	Prescriber
_____	_____	_____
Medication	Dosage	Prescriber
_____	_____	_____
Medication	Dosage	Prescriber

If you have current healthcare or psychiatric providers, please indicate:

_____	_____
Primary Care Physician	Last Physical Exam
_____	_____
Address	Phone
_____	_____
City/State/Zip	Fax
_____	_____
Psychiatrist	Dates of Service
_____	_____
Address	Phone
_____	_____
City/State/Zip	Fax

_____ _____

Other Agency/Provider Dates of Service

_____ _____

Address Phone

_____ _____

City/State/Zip Fax

Emergency contact

Name _____ Relationship _____

Street Address _____ City/State/Zip _____

Primary Phone (_____) _____-_____ OK to leave message? _____

Secondary Phone (_____) _____-_____ OK to leave message? _____

Health & Medical History

At your birth, what were your parent(s) ages? _____

Are you aware of any prenatal concerns or issues with your delivery? Yes No

If yes, please explain _____

_____

Did you have any problems/injuries/medical interventions as a newborn infant? Yes No

If yes, please explain _____

_____

Did you receive your immunizations as a child? Yes No On schedule? Yes No

If yes, please explain _____

_____

Did you have any developmental delays or difficulty meeting milestones? Yes No

If yes, please explain _____

_____

Please indicate if and when you have had any of the following:

	Never	0-12 months	13-24 months	2-4 years	4-7 years	Since 7 years (please indicate age)
Ear infection(s)/myringotomy tubes						
Rashes or skin problems						
Meningitis						
Seizures (convulsions) or spells						
High fevers (over 103F or 39C)						
Diabetes						
Pneumonia						
Asthma						
Sinus Problems						
Chronic Colds						
HIV/AIDS						
Encephalitis						
Tonsillitis						
Tonsillectomy						
Adenoidectomy						
Mastoidectomy						
Diphtheria						
Croup						
Influenza						
Polio						
Whooping Cough						
Slow weight gain						
Trouble with ears or hearing						
Trouble with eyes or vision						

Bowel problems						
Serious injury(ies)						
Head injury(ies)						
Food allergy(ies)						
Anaphylactic						
Other allergies						
Anemia (low blood count)						
Lead poisoning						
Other poisoning or overdose						
Heart problems						
Kidney or urinary problems						
Got sick after immunization						
Other important illness(es) (specify):						
Medication(s) used over a long period (specify):						

Have you ever been hospitalized for a medical issue? Yes No If yes, indicate below:

_____ _____ _____

Hospital Dates Reason

_____ _____ _____

Hospital Dates Reason

_____ _____ _____

Hospital Dates Reason

Have you ever been in mental health treatment? Yes No If yes, indicate below:

_____	_____	_____
Agency/Provider	Dates	Issues
_____	_____	_____
Agency/Provider	Dates	Issues
_____	_____	_____
Agency/Provider	Dates	Issues

Family History

Please address the following with regard to our biological parents:

Parent name _____ Relationship to you _____

Age _____ General health _____

School level completed _____ Present Occupation _____

Parent name _____ Relationship to you _____

Age _____ General health _____

School level completed _____ Present Occupation _____

Please address the following with regard to adoptive parents (if applicable):

Parent name _____ Relationship to you _____

Age _____ General health _____

School level completed _____ Present Occupation _____

Parent name _____ Relationship to you _____

Age _____ General health _____

School level completed _____ Present Occupation _____

Please address the following with regard to step parents (if applicable):

Parent name _____ Relationship to you _____

Age _____ General health _____

School level completed _____ Present Occupation _____

Parent name _____ Relationship to you _____

Age _____ General health _____

School level completed _____ Present Occupation _____

Who primarily raised you? _____

Are your parents divorced/separated? Yes No

If yes, how old were you at the time of separation? _____

How would you describe your relationship with your parent(s)? _____

_____

Primary language spoken at home:_____

Any other language(s) spoken at home? Yes No If yes, what?_____

Do you have any siblings/half siblings? Yes No If yes, please complete below.

Siblings:

First Name	Age	School/grade/occupation	Biological/adopted/step/half?

(Please circle as appropriate: Y=Yes; N=No; U=Unknown)

Have you ever observed abuse of any family member in your family of origin?

Y N U

Have you ever been abused/neglected in your family of origin?

Y N U

Have you ever experienced abuse outside of your family of origin?

Y N U

Have you experienced the loss by death of a:

Parent or Guardian? Y N If yes, whom?_____

Date: _____

Other family member? Y N If yes, whom?_____

Date: _____

Close friend? Y N If yes, whom?_____

Date: _____

Please complete the following questions about members of your family.

Family History	Parent/Guardian 1: _____	Parent/Guardian 2: _____	Sibling: _____	Sibling: _____	Other (specify)
Hyperactive as a child					
Trouble learning to read					
Trouble with arithmetic					
Trouble with writing					
Kept back in school					
In Special Education					
Speech or language problems					
Behavior problems in childhood					
In trouble as a teenager					
Depression					
Anxiety					
Eating Disorder					
Alcohol or Drug Abuse					
Suicide attempts					
Hospitalizations for Emotional/Psychological Problems					
Chronic Physical Illness					
Incarceration (jail/prison)					
Anger Problems					
Other mental illness					