SELBY PSYCHOLOGICAL SERVICES, PLLC
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Child Intake Form

The following information is requested by Selby Psychological Services (SPS) to best serve your minor child(ren) [please see applicable information in our ***Outpatient Services Contract*** regarding your minor(s)]. Please clearly print your response to each question. This will help save time in your child's first session. *Some parts may not be applicable to a younger child, but may be applicable to an older teenager (e.g., substance use information). If an area is not applicable please denote it as N/A.* If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your psychologist. Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Today's Date: _____

Name_____ Date of Birth_____ Age_____

Address_____ City/State_____ Zip_____

Social Security Number_____ Gender: F___ M___

Home Phone_____ Work Phone_____ E-mail _____

Marital Status_____ Employment_____

Emergency contact_____ Relationship to you_____

Their Home Phone_____ Their Work Phone_____

Who Referred You? _____

If you are Self-Referred, how did you hear about Selby Psychological Services?_____

Primary Care Provider_____ Phone Number_____

Other Mental Health Provider (if any) _____ Phone Number _____

Insurance Information

Name of Insured:_____ Gender _____

Insured's Street Address:_____ City/St/Zip_____

Patient's Relationship to Insured:_____ Insured's Birth Date_____

Insured's Social Security #: _____

Name of Insurance Company: _____

Employer and/or Group Number of plan: _____

Insurance ID Number:_____

SECTION II: DESCRIPTION OF PRESENTING PROBLEM

Please describe why you decided to seek services at SPS for your child:

Please tell us what you want your child to work on or change in psychotherapy:

How long has this been a significant problem for your child (Please be specific)?

How would you estimate the severity of the problem at this time? (Place "X" on the line below)

Mild---------- Moderate---------- Serious---------- Severe

What symptoms are related to this problem? Please check **all** that apply for your child **now**:

__overeating	__restless	__rapid heart rate	__compulsive behaviors
__taking drugs	__depressed mood	__sweating	__fears/phobias
__odd behavior/thoughts	__crying	__trembling or shaking	__anxiety
__recent weight gain	__difficulty concentrating	__shortness of breath	__vomiting
__recent weight loss	__low motivation	__muscle tension	__distrust
__recent appetite changes	__aggressive behavior	__outbursts of temper	__jumpy
__social withdrawal	__feelings of worthlessness	__nightmares	__restricting food
__suicidal thinking	__impulsive/risky behavior	__easily distracted	__fatigue/loss of energy
__dizziness	__sleeping too much	__decreased need for sleep	__obsessions
__difficulty falling asleep	__problems at work/school	__financial problems	__relationship problems
__difficulty staying asleep	__housing problems	__drinking alcohol	__chronic pain

__ experienced a traumatic event other: _____

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g., problem with work or school, relationship ending, divorce, past trauma, etc.):

In the past, what has been helpful to your child in dealing with this problem?

SECTION III: MEDICAL HISTORY

Please list any significant past or current health, medical, or psychiatric issues (including anything resulting in hospitalizations) for your child.

Dates	Problem	Treatment	Hospitalization (Y/N)

Has your child ever had treatment by, or are your child currently working with a psychiatrist, psychologist, therapist, or counselor?

Yes ___ No ___

If yes, please complete the relevant information below:

Dates	Problem	Where	Name of Provider	Helpful (Y/N)

Has your child ever been given a mental health diagnosis in the past from a mental health professional? Yes___ No___

If yes, as you understand it, what is/was that diagnosis? _____

_____

(Continue to next page)

SECTION IV: MEDICATIONS AND SUBSTANCES USED

If applicable, please list all **prescription medications** your child is now taking or has taken in the past three months, including birth control pills, vitamins, herbs and supplements.

Medication	Dosage	Prescribing Provider	Length of Prescription	Helpful (Y/N)

If applicable, please list all **other non-prescription drugs and/or substances used (illicit or other) including alcohol.**

Drug/Substance	Amount Used	Month/Years Using this Drug or Substance	Purpose of using this Drug or Substance

If applicable, how many cigarettes does your child smoke per day? _____

If applicable, how many caffeinated beverages does your drink per day? _____

Of what type: Coffee _____ Tea _____ Soda (diet or otherwise) _____

Other_____