



9915 E. Bell Rd., Suite 120, Scottsdale, AZ 85260

INTAKE INFORMATION

Date: _____ Referred by: Self Doctor Friend Family member Other

Child's Name _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Your (Parent's) Cell Phone _____ Parent's Email address _____

Is it okay to leave a message? Home: Yes / No Cell: Yes/No

Name of other Parent (if applicable) _____ Phone _____

Name of Step-Parent (if applicable) _____ Phone _____

Emergency Contact (if different from above) _____ Phone _____

School _____ Current Grade _____

School Counselor (if applicable) _____ Phone _____

Primary Care Physician _____ Phone _____

Psychiatrist (if applicable) _____ Phone _____

Other Service Provider _____ Phone _____

Areas of concern
Please check all
that apply

| | | | | | | | |
|--------------------------|----------------------|--------------------------|-------------------------|--------------------------|---------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | Family Relationships | <input type="checkbox"/> | Grief/Loss | <input type="checkbox"/> | Social Difficulties | <input type="checkbox"/> | Developmental Delays/Problems |
| <input type="checkbox"/> | Parenting Struggles | <input type="checkbox"/> | Traumatic event(s) | <input type="checkbox"/> | Sleep Problems | <input type="checkbox"/> | Substance use |
| <input type="checkbox"/> | School | <input type="checkbox"/> | Identity/Self-Esteem | <input type="checkbox"/> | Eating Behaviors | <input type="checkbox"/> | Sexual Issues |
| <input type="checkbox"/> | Poor Concentration | <input type="checkbox"/> | Emotional Difficulties | <input type="checkbox"/> | Thoughts of Suicide | <input type="checkbox"/> | Attachment Problems |
| <input type="checkbox"/> | Behavior problems | <input type="checkbox"/> | Adjustment Difficulties | <input type="checkbox"/> | Body Image Issues | <input type="checkbox"/> | Other |

Client/Family Information:

Parent(s) Marital Status S / M / DP / D / W

Parent(s) occupation(s) _____

What are the names and ages of all people living in your home? What is his/her relationship to the client?

Are there any other immediate family members who don't live with you?

Are there any aspects of your home/living environment with which you are dissatisfied?

What difficulties are you/your child currently experiencing?

How long have these difficulties been a concern?

How do these difficulties affect you and your family?

Are you receiving help for these difficulties anywhere else? Where? Is it helpful?

What do you hope to accomplish by participating in counseling? How will you know if you and your child are making progress?

Have you or anyone else in your family received counseling in the past? When? Was it for related or different difficulties? Was it helpful?

Is there anyone not present today that you would like included in future counseling sessions?

Please list any medications your child is currently taking.

Please list any psychiatric medications that your child has taken in the past. Where they helpful?

Has your child ever been hospitalized for psychiatric treatment? If so, when and where was he/she hospitalized?

Does your child have any medical conditions or health problems? If so, is he/she receiving treatment?

Please list any immediate or extended family members who have suffered with mental illness or substance abuse.

Has your child ever attempted suicide? If yes, please provide details.

Do you believe your child currently drinks alcohol? Approximately how many drinks per week?

Do you believe your child currently uses recreational drugs? How often?

Is your child or yourself involved in any legal proceedings?

Who are your primary supports in life? Please include both formal (e.g., groups) and informal (e.g., friends, family).

Is there any information you would like to provide regarding your culture, your spiritual/religious beliefs and practices or any other significant aspects of your or your child's life?
