EVAN FREEDMAN PhD, ABPP
Licensed Psychologist #2306

CHILD AND FAMILY INTAKE FORM

Please complete all pages of form.

Today's Date:_____

Child's Full Name:_____ Social Security#: _____
Date of Birth: _____ Gender: _____
Referred by: _____ Primary Care Physician: _____

Child resides with: _____ Relationship to child: _____
Child's Primary Address: _____
Billing Address: _____

Parent/Caregiver Name: _____ Social Security#: _____
Home Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO
Work Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO
Cell Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO
Email: _____

Parent/Caregiver Name: _____ Social Security#: _____
Home Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO
Work Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO
Cell Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO
Email: _____

PRIMARY INSURANCE INFORMATION

(information found on insurance card)

Insurance Company: _____ Phone#: _____
Insurance Company Address: _____
Subscriber's Name: _____ Relationship to client: _____
Subscriber's Address: _____
ID#: _____ Group/Plan #: _____

SECONDARY INSURANCE INFORMATION

(information found on insurance card)

Insurance Company: _____ Phone#: _____
Insurance Company Address: _____
Subscriber's Name: _____ Relationship to client: _____
Subscriber's Address: _____
ID#: _____ Group/Plan #: _____

COUNSELOR'S NOTES (for office use only)

Date	Dx code	Dx	Provider Signature

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CHILD'S MEDICAL HISTORY

How is your child's general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Briefly describe your primary concerns and why you have brought your child to the office:
_____
_____

When was your child's last comprehensive medical evaluation? _____

Has your child ever been hospitalized for psychological reasons? ☐ Yes ☐ No
If yes, when and where? _____

Please check whether your child currently has, or has ever had any of the following:

__drug/alcohol abuse	__sleeping problems	__changes in appetite	__flashbacks
__running away	__frequent headaches	__epilepsy or seizures	__ulcers
__disturbing thoughts	__lack of interest	__sexual abuse	__depression
__memory problems	__low self-esteem	__speech problems	__confusion
__irritability	__emotional abuse	__hearing problems	__stress
__bowel problems	__irregular heartbeat	__visual problems	__bedwetting
__suicidal ideations/attempts	__feelings of hopelessness	__homicidal thoughts	__weight loss
__sexual concerns	__difficulty managing anger	__asthma	__head trauma
__chronic illnesses	__family/relationship issues	__communication problems	__mood swings
__phobias:_____	__hormone disorder	__difficulty concentrating	__anxiety
__physical abuse or neglect	__panic attacks	__serious infection	__allergies
__racing thoughts	__frequent stomachaches	__feelings or paranoia	__broken bones
__school/work difficulties	__blood pressure concerns	__problems with coordination	
__frequent or uncontrolled crying		__self-destructive or self-injurious behavior	

__Other physical or emotional issues (please describe):
_____

Is your child currently taking medication? ☐ Yes ☐ No
Medication: _____ Dosage: _____ Date Started: _____
Medication: _____ Dosage: _____ Date Started: _____
Medication: _____ Dosage: _____ Date Started: _____

List any serious illnesses for which the child required hospitalization or surgical operation:

Illness	Year	Doctor	Hospital

Has your child ever received psychological, substance abuse, or psychiatric services?

Service	Year	Doctor	Issue at Time

FAMILY SITUATION

Relationship/Marital Status of parents: ☐ Single ☐ Involved ☐ Engaged ☐ Cohabitating ☐ Remarried ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Names and ages of other adults & children residing in the home:

Name	Age	Relationship to Client

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Are there any family members experiencing significant medical problems or substance abuse?
(Please indicate relationship to child):

Medical Problems-
Past: _____
Present: _____

Alcohol
Past: _____
Present: _____

Marijuana
Past: _____
Present: _____

Drugs
Past: _____
Present: _____

Tobacco
Past: _____
Present: _____

Have you had previous counseling? ☐ Yes ☐ No
If yes, with whom? _____ When? _____
Would it help to contact previous counselor(s)? ☐ Yes ☐ No

GOALS FOR THERAPY

What are the goals and outcomes you would like to achieve for yourself/child with therapy?

_____
_____
_____
_____

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