Intake Form

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

PATIENT (S) _____ **RESPONSIBLE PARTY** _____

Date of Birth _____ Gender _____ Relation to patient _____

Address _____ Address (if different) _____

_____ _____

City, State _____ Zip _____ City, State _____ Zip _____

Home Phone _____ Home Phone (if different) _____

Work Phone _____ Work Phone (if different) _____

Cell Phone _____ Cell Phone (if different) _____

Please indicate with an * which phone numbers we may NOT leave a message.

Any special instructions when calling or leaving messages? _____

_____

Relative or friend in case of emergency _____

Name Phone # Relationship

How did you hear about Playmore & Prosper? _____

What is the reason for seeking support at this time? _____

_____

_____

_____

How could your life be better?

OVER

FAMILY INFORMATION

NAME	M/F	Age	See Key	CUSTODY & HOUSEHOLD	EDUCATION	OCCUPATION
Parent (s)						
Children/Step Children/Siblings						
1.						
2.						
3.						
4.						
5.						
6.						
Important Others (Grandparents, uncles, aunts, room mates, neighbors, etc.)						
1.						
2.						
3.						
4.						

KEY

please indicate the following:
Substance use = Al: alcohol use / Sm: smoker / Dr: drug use
Mental health concerns = D: depression / A: anxiety / O: other
Medications = P: prescription medication
Relation = :adopted / : half sibling / :step sibling

MEDICAL INFORMATION

1. **Patient Name** _____

Physician: Name/Practice _____

Address_____ Phone _____

Date of last physical exam _____

How is the patient's general health now? _____

Is he/she presently being treated by a physician for any physical condition? _____

Please list any serious illness? _____

Has the patient ever had surgery? (List) _____

Please list all medications & dose _____

_____

How many hours a night on average does the patient sleep?_____

On a scale of 1-10 (10 being best) how healthy is the client's diet believed to be?_____

On a scale of 1-10 (10 being best) how healthy is the client's physical activity level believed to be?_____

Were there any concerns or problems during pregnancy with the patient? (List)_____

_____

Were there any concerns or problems during birthing with the patient? (List)_____

_____

Were there any early childhood health issues with the patient? (List)_____

_____

Any previous diagnosis? _____

Has the patient received treatment/services for similar concerns prior to this assessment: (please list & date)

_____

_____

_____

Have other family members received treatment/services that may have affected the patient:

_____

Symptoms

PLEASE MARK ALL THAT APPLY:

Thinking & Feeling

___Anger	___Hallucinations	___Perfectionism
___Anxiety, nervous	___Hopelessness	___Pessimism
___Decreased Energy	___Irritability	___Racing thoughts
___Delusions	___Manic	___School/Work Problems
___Depressed Mood	___Mood Swings	___Somatic Complaints
___Disruption of Thought Process/Content	___Oppositional	___Suicidal Thoughts
___Grief	___Panic Attacks	___Worthlessness
___Guilt	___Paranoia	___Other (Specify)

Doing

___Argues, "talks back," smart aleck, defiant	___Immature, "clowns around," has only younger playmates	___Speech difficulties
___Bullies, intimidates, bossy	___Interrupts, talks out	___Sexual – preoccupation, inappropriate sexual behaviors
___Cheats	___Lacks organization, unprepared	___Shy, timid
___Cruel to animals	___Lacks respect for authority	___Stubborn
___Conflicts with authority	___Legal difficulties – truancy, loitering, vandalism, stealing	___Swearing, potty mouth, foul language
___Competitive	___Likes to be alone	___Suicide Attempt
___Complains	___Lying	___Temper tantrums, rages
___Cries easily, feelings hurt easily	___Low frustration tolerance, irritability, reactive	___Thumb sucking, hair chewing
___Criminal Activity	___Nail biting	___Tics – involuntary rapid movements, noises, or words
___Dawdles, wastes time	___Needs high degree supervision	___Truant, school avoiding
___Disrupts family activities	___Oppositional, resists, refuses, does not comply	___Underactive, slow moving, lethargic
___Disobedient, uncooperative, refuses, doesn't follow rules	___Prejudiced, insulting of differences, name calling	___Uncoordinated, accident prone
___Distractible, inattentive, poor concentration, slow to respond	___Pouts	___Wetting or soiling the bed or clothes
___Dropping out of school	___Relational conflicts	___Other (Specify)
___Eating – more/less, refuses	___Rocking, repetitive movements	
___Failure in school	___Runs away	
___Fighting, hitting, violent, aggressive, threatens, destructive	___Self-harming behaviors – biting or hitting self, head banging, scratching, cutting	
___Fire setting	___Sleep Disturbance	
___Hyperactive, overactive, restless, fidgety		

Stressors

PLEASE MARK ALL THAT APPLY:

___Abuse – physical, sexual, emotional ___Alcohol or substance use ___Alcohol or substance witness ___Bullied, teased, or picked on ___Career concerns ___Childhood difficulties ___Concern for others, caretaker, over sensitive ___Change (list)_____ ___Custody concerns or struggles ___Dependent ___Developmental delays ___Divorce or separation ___Family conflicts	___Family health ___Family Finances ___Few or no friends ___Disruption of Thought Process/Content ___Grief ___Guilt ___Health – illness, medical concern, physical challenges ___Learning disability ___Legal matters ___Loss of friends ___Low income	___Marital conflict ___Nightmares ___Neighborhood problems ___Over weight ___Move ___Neglect ___New school ___Relationship problems ___School problems ___Threats, violence ___Work problems ___Other (Specify)

Has the patient experienced or witnessed any of the following as a child? **PLEASE MARK ALL THAT APPLY:**

___Car accident ___Family violence / abuse ___Community violence ___Life threatening experience ___None of the above	___Emotional abuse ___Fire ___Serious Physical illness ___Neglect	___Natural disaster ___Physical Aggression ___Sexual assault/molestation ___Other (Specify)

What more should we know about anything indicated in this form, or missing from this form?

_____

_____

_____

_____

_____

_____