Anne Wright, PhD, PLLC
Child & Adolescent Assessment

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ADULT INTAKE FORM

Full Name: _____ SSN: _____
Date of Birth: _____ Gender: ☐Male ☐Female
Address: _____
_____
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
Referred by (Name/Agency): _____
Primary Care Physician: _____ Phone: _____

School/Employment (if applicable):
Current School/College: _____ Grade/year: _____
Highest Educational Level completed (circle): 8 9 10 11 12 13 14 15 16 17 18 19+
Occupation: _____
Employer: _____ For how long? _____

Marital Status:
☐ Single ☐ Involved ☐ Cohabitating ☐ Engaged
☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Please describe your ethnic background: _____

List names and ages of all individuals residing in your household:
Name: _____ Age: ___ Relationship to you: _____
Name: _____ Age: ___ Relationship to you: _____
Name: _____ Age: ___ Relationship to you: _____
Name: _____ Age: ___ Relationship to you: _____

PRIMARY INSURANCE INFORMATION
Insurance Company:_____ Phone #: _____
Ins. Co. Address: _____
Subscriber's Name:_____ Subscriber Birthdate: _____
ID #: _____ Group/Plan #: _____

SECONDARY INSURANCE INFORMATION
Insurance Company:_____ Phone #: _____
Ins. Co. Address: _____
Subscriber's Name:_____ Subscriber Birthdate: _____
ID #: _____ Group/Plan #: _____

REASON FOR VISIT

Briefly describe your primary concerns and why you sought these services:

_____

_____

_____

FAMILY SITUATION

Relationship Status of Parents:

☐Cohabitating ☐Married ☐Separated ☐ Divorced ☐Widowed ☐Remarried (circle Mother, Father, or Both)

Mother's Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Father's Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

FAMILY HISTORY

List any ***immediate or extended family members*** with a history of concerns in the areas listed below. Please indicate their relationship to the child and provide more detailed information, such as specific diagnosis. There is additional space on the final page if needed.

Chronic Physical Health Issues

Past: _____

_____

Present: _____

_____

Mental Health Concerns

Past: _____

_____

Present: _____

_____

Learning and/or Attention Concerns

Past: _____

_____

Present: _____

_____

Developmental Delay and/or Autism Spectrum Disorders

Past: _____

_____

Present: _____

_____

Drug/Alcohol Dependence or Abuse

Past: _____

_____

Present: _____

_____

Physical/Sexual Abuse and/or Neglect

Past: _____

_____

Present: _____

_____

Domestic Violence

Past: _____

_____

Present: _____

_____

MEDICAL HISTORY

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐Poor

When was your last comprehensive medical evaluation? _____

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

Illness: _____ Year: ___ Doctor/Hospital: _____

Illness: _____ Year: ___ Doctor/Hospital: _____

Illness: _____ Year: ___ Doctor/Hospital: _____

Are you currently taking any medications/supplements/vitamins? ☐Yes ☐No

Medication:_____ Dosage: _____ Date Started: _____ Prescriber: _____

Medication:_____ Dosage: _____ Date Started: _____ Prescriber: _____

Medication:_____ Dosage: _____ Date Started: _____ Prescriber: _____

Supplement/Vitamin:_____ Dosage: _____ Date Started: _____

Supplement/Vitamin:_____ Dosage: _____ Date Started: _____

List previous or current counseling, substance abuse services, psychiatric services, hospitalizations for mental health reasons, or psychological, speech/language, or occupational therapy assessment or services.

Service: _____ Year Started: _____ Currently receiving services? ☐Yes ☐No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? ☐Yes ☐No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? ☐Yes ☐No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? ☐Yes ☐No

Doctor/Therapist/Agency: _____

Please check whether you currently have or have ever had any of the following:

Attention/Educational Issues	**Developmental/Medical Issues**	**Emotional/Behavioral Issues**
_ Inattention	_ Speech delay/problems	_ Verbal aggression/defiance
_ Organizational difficulties	_ Fine/Gross motor delay	_ Difficulty managing anger
_ Academic delays/concerns	_ Hearing problems	_ Physically aggressive
_ Memory concerns	_ Vision problems	_ Sexualized behavior
_ Peer conflict/bullying	_ Bedwetting/bowel problems	_ Low self-esteem
	_ Head injury/concussion	_ Depressed mood/withdrawn
Stresses/Trauma	_ Frequent stomachaches	_ Mood swings
_ Family issues/conflict	_ Frequent headaches	_ Anxiety
_ Witness to domestic violence	_ Epilepsy or seizures	_ Ritualistic/Repetitive behaviors
_ Multiple moves	_ Sleeping problems	_ Irritability
_ Deaths or losses	_ Self-injurious behavior	_ Panic Attacks
_ Chronic illness in family		_ Disturbing thoughts
_ History of sexual abuse		_ Feelings of hopelessness
_ History of physical abuse		_ Extreme fears
_ History of emotional abuse		_ Running away
_ History of neglect		_ Suicidal thoughts/attempts
_ Legal issues		_ Drug/alcohol use

Thank you for providing this information.
Bring this completed form to the initial appointment, and attach a current photo.

Additional comments/personal or family history: