KATHRYN S. STEINMAN, PSY.D.
Licensed Psychologist

PATIENT INTAKE FORM

DATE: ________________

Patient Name: ____

Parent/Guardian Name: ____

Patient Address: ____

____

Phone: _________________________ (home) __________________________ (work/cell)

E-mail Address:____

Referred by: ____

Reason for Initial Visit:

____

____

PERSONAL INFORMATION

Date of Birth: ______________________________

Age: __________________ **Current Grade:** ___________________

Mother's Name: _____________________________________ **Age:** __________

Mother's Occupation/Employer:____

Father's Name: _______________________________________ **Age:** __________

Father's Occupation/Employer: ____

Parents' Marital Status: ________ **Married** ________ **Separated**
________ **Divorced**________ **Other (Specify** _____________**)**

Please indicate any concerns regarding parent relationship/status:

____

____

Siblings (names, ages, and schools attending):

____

____

7910 Woodmont Avenue / Suite 1101 / Bethesda, MD 20814
drkathryn@steinmantherapy.com / Phone: 301.787.4459

Please indicate any concerns regarding relationship with sibling (s):

____

____

Place of Birth: ____

Place of Upbringing: ____

Primary Caregiver (s): ____

DEVELOPMENTAL INFORMATION

Any problems during mother's pregnancy: ________ **Y** ________ **N**

If yes, please explain:

____

Birth: ________ Full term _________ Premature (How many weeks gestation? _________)

Please indicate approx. age of developmental milestones:

________ Crawling ________ Walking ________ Talking ________ Puberty

Please describe any difficulties your child may have had with any of these milestones:

____

____

EDUCATION

Please indicate where your child attends/attended, average grades, and any information worth mentioning/of concern.

High School:

____

Middle School:

____

Elementary School:

____

Has your child ever been diagnosed with a learning disability and/or had behavioral difficulties needing professional intervention? ________ Y ________ N

If yes, please explain:

____

____

CURRENT SYMPTOMS AND ISSUES OF CONCERN

Please check all that apply.

	Symptom/Issue		Symptom/Issue
________	Fatigue	________	Perfectionism
________	Stress	________	Panic Attacks
________	Sleep problems	________	Thoughts of Harming Self
________	Sadness/Depression	________	Physical Problems
________	Anger	________	Dizziness
________	Worry	________	Weight Change
________	Memory problems	________	Loneliness/Isolation
________	Low Energy	________	School Difficulties
________	Eating Behavior Issues	________	Obsessive/Compulsiveness
________	Nervousness	________	Impulsiveness
________	Social problems	________	Heart Palpitations
________	Family problems	________	Sick Often
________	Mood Swings	________	Headaches
________	Low Self-esteem	________	Easily Distracted
________	Hopelessness	________	Thoughts of Harming Others
________	Irritability	________	Nightmares
________	Poor Concentration	________	Disorganized Thoughts
________	Anxiety	________	Violent Behavior
________	Substance Abuse		

PSYCHIATRIC HISTORY

Has your child ever been in psychotherapy before? _______Y _______ N
If yes, please explain:

____

____

Has your child ever been hospitalized for a psychiatric problem? _______ Y _______ N
If yes, please explain:

____

____

Has your child ever attempted or had thoughts of hurting himself/herself? ______ Y ______ N
If yes, please explain:

____

____

Has your child ever attempted or had thoughts of hurting another person? ______ Y ______ N
If yes, please explain:

____

____

Is your child currently seeing a psychiatrist? _______ Y _______ N

If yes, please provide his/her name and phone number:

____

Is there a family history of psychiatric problems? ________ Y ________ N
If yes, please explain:

____
____

Have there been any substance abuse/alcohol problems in the family? _______ Y _______ N
If yes, please explain:

____
____

MEDICAL INFORMATION

Please provide your contact information for your child's primary care physician (name and number):

____

Please indicate if your child has had any serious illnesses or injuries (past or present):

____
____

MEDICATIONS

Please list all medications (including vitamins) your child is currently taking, including dosage and frequency:

____
____
____

EMERGENCY CONTACT

Name and number of person (s) to contact in case of an emergency (if parents unavailable):

____

Relationship to Patient: ____

I certify that the above information is accurate. I understand that this information will be included in my child's clinical record and will be used and disclosed only as described in the document explaining Dr. Steinman's professional services and business policies, as well as the "Notice of Policies and Practices to Protect the Privacy of Patients' Health Information."

______________________________________ ________________

Parent/Guardian Signature **Date**