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: _____
_____

CURRENT SYMPTOMS AND ISSUES OF CONCERN

Please check all that apply.

	Symptom/Issue		Symptom/Issue
_____	Anxiety	_____	School Difficulties
_____	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	_____	Easily Distracted
_____	Eating Behavior Issues	_____	Obsessive/Compulsiveness
_____	Nervousness	_____	Impulsiveness
_____	Social problems	_____	Heart Palpitations
_____	Family problems	_____	Sick Often
_____	Mood Swings	_____	Headaches
_____	Low Self-esteem	_____	Nightmares
_____	Hopelessness	_____	Thoughts of Harming Others
_____	Irritability	_____	Disorganized Thoughts
_____	Poor Concentration	_____	Violent Behavior
_____	Substance Abuse	_____	Other _____

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 _____)

Place of Birth/Upbringing: _____

Please indicate any concerns regarding parent relationship/status:

_____

_____

Siblings (names, ages, and schools attending):

_____

_____

Please indicate any concerns regarding relationship with sibling(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: _____
_____

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, injuries, or conditions (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 to the best of my knowledge. 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