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Beljan Psychological Services
Psychotherapy Family and Individual Intake Form

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____Employment: _____

Home Address: _____ City_____ ST ____Zip_____

Phone: HM:_____ C: _____

Email: _____

Person who referred you: _____

Information

Spouse/ Co-parent's Name: _____

Age:_____

Education: _____ Occupation: _____

Number of children and ages:_____

Others living with you:_____

You are: single married separated divorced re-married widowed

Spouse/ Co-parent's Name: _____

Age:_____

Education: _____ Occupation: _____

Number of children and ages:_____

Others living with you:_____

Referral Information

Briefly describe the main reasons you are seeking services.

_____

What have you tried to address the concern?

_____

_____

What worked best? _____

_____

What has not worked? _____

_____

_____

What do you hope to will happen through this process? _____

_____

_____

Who lives in the household with you?

_____

_____

Educational History

All Children:

Grade:	Placement	Current and Past Schools of Child(ren)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(*Placement: Gifted Regular Resource Special Education)*

Other_____

Any grades that were skipped? _____ repeated? _____

Teachers reported problems in:

_____

_____

Reading	Spelling	Arithmetic	Writing
Attention	Behavior	Social Adjustment	Hyperactivity
Impulsivity	Easily Distracted	Other: _____	Other: _____

Please describe specific problems noted:

_____

_____

_____

Social Behavior

Please explain any pertinent issues regarding social behavior: _____

_____

_____

Describe the quality of friendships and or peer relationships at school or within social settings:

_____

_____

_____

Medical History

Client Mental Health History: (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning Difficulties	Mental Illness	Neurological Illness	Seizures
Psychiatric Disorder	Schizophrenia	Depression	Bipolar Disorder
Anxiety	Suicidal Ideation	Alcoholism	Drug Abuse
Legal Problems	Arrests	Obsessive-Compulsive Disorder	Personality Disorder
Other: _____	Other: _____	Other: _____	Other: _____

Please explain:

_____

_____

_____

Primary Physician and address: _____

_____

_____

Has vision been checked? **Y** or **N** Any problems: _____

Has hearing been checked? **Y** or **N** Any problems: _____

CT or MRI Date obtained? _____ Results: _____

EEG Date obtained? _____ Results:_____ Other tests and results:_____

Symptoms and/or conditions:

Failure-to-thrive	Febrile seizures	Epilepsy	Staring spells
Head injuries	Meningitis	Encephalitis	Asthma
Allergies	Diabetes	Loss of Consciousness	Abdominal pains
Vomiting	Headaches	Ear infections	Sleep difficulties
Sleep walking or talking	Eating difficulties	Eating disorder	Facial or other Tics
Repetitive movements	Impulsivity	Temper tantrums	Nail biting
Clumsiness	Head banging	Self-injurious behavior	Anxiety
Physical injuries	Lead poisoning/toxic ingestion		Depression
Other: _____	Other: _____	Other: _____	Other: _____

Please explain the age of occurrence, relevant information, and interventions of any conditions circled above: _____

_____

_____

Current medications and reasons: _____

_____

List serious illnesses/injuries/hospitalizations/surgeries

Date	Incident (explain)
_____	_____
_____	_____
_____	_____

Pregnancy and Birth History

Concerns or complications with birth history of self, spouse, and/or children (complications, substance exposure, postpartum, infertility, etc):_____

_____

_____

_____

_____

Known health problems during pregnancy (circle all that apply) (self or children)

Toxemia	Hypertension	Gestational Diabetes	Trauma
Fever	Allergies	Smoking	Alcohol Use
Drug Use	Antibiotics	Depression	Anxiety
Blood Incompatibility	Injury	Accidents	Emotional Abuse
Physical Abuse	Sexual Abuse	Spouses abuse:	Other:
Mental Illness	Sexually Trans. Disease	Other:	Other:

Please explain: _____

_____

List any medications, tobacco use, alcohol use, or drugs taken by mother during pregnancy: _____

_____

Please list current and past psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/ Occupation	Dates Seen	For What?	Describe Progress

Parental History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning Difficulties	Mental Illness	Neurological Illness	Seizures
Psychiatric Disorder	Schizophrenia	Depression	Bipolar Disorder
Anxiety	Suicide/	Alcoholism	Drug Abuse
Legal Problems	Arrests	Obsessive-Compulsive	Personality Disorder
Suicidal Ideation		Disorder	
Other: _____	Other: _____	Other: _____	Other: _____

Please explain:

_____

_____

_____

_____

_____

Family Background

Extended Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning Difficulties	Mental Illness	Neurological Illness	Seizures
Psychiatric Disorder	Schizophrenia	Depression	Bipolar Disorder
Anxiety	Suicide	Alcoholism	Drug Abuse
Legal Problems	Arrests	Obsessive-Compulsive	Personality Disorder
Suicidal Ideation		Disorder	

Other: _____ Other: _____ Other: _____ Other: _____

Please explain:

_____

_____

_____

Has you or the family experienced: (circle all that apply):

death of a loved one	separation from a loved one	emotional trauma	sexual abuse
family conflict	marital conflict	physical abuse	emotional abuse
domestic violence	suicidal ideation	self-injurious behaviors	neglect

Current members of the household and religious preference: _____

_____

Marital or long term relationship history:

_____

_____

_____

Describe your parenting styles;

_____

_____

_____

_____

Areas of improvement:

_____

_____

Feelings about parenting:

_____

_____

Dicipline methods:

_____

_____

_____

_____

Emotional needs of child(ren) and or sensitivities (tags, clothing, tactile, texture, etc),:

_____

_____

_____

_____

Major transitions (moving, schools, death/loss, divorce, etc).:

_____

_____

_____

Please add any additional information you would like us to know:

_____

_____

_____