NASSAU PSYCHOLOGY P.C.

Nassau Psychology P.C.

123 Grove Ave. suite 216
CEDARHURST NY 11516-2300
5163508564

2. Pediatric Intake Form

Client Full Name:

Name of legal guardian number #1:

Relationship to Child:

Phone number:

Email Address:

Name of legal guardian number #2:

Relationship to Child:

Phone number:

Email Address:

What is the reason the client is seeking therapy?:

Areas of Concern:

(check all that apply)

- [ ] Ability to Control Temper
- [ ] Attention Span/Ability to Concentrate/Distractibility
- [ ] Blended Family/Divorce/Parents Separating
- [ ] Bullying
- [ ] Eating Habits/Bingeing/Purging/Starving
- [ ] Friendship/Peer Relationships

- [ ] Grief/loss
- [ ] Hyperactivity/Tics
- [ ] Gender identity/sexual orientation
- [ ] Impulse Control
- [ ] Memory
- [ ] Relationship with Parents/Caregivers
- [ ] Relationships with Siblings
- [ ] Relationships with Friends/Peers
- [ ] Repetitive Behaviors / Obsessions / Compulsions
- [ ] School Performance
- [ ] Self Harm
- [ ] Shoplifting/Stealing
- [ ] Shyness
- [ ] Social Skills
- [ ] Strange Thoughts/Strange Experiences

Current Symptoms

(check all that apply)

- [ ] Anger
- [ ] Anxiety
- [ ] Appetite Issue
- [ ] Avoidance
- [ ] Crying Spells
- [ ] Depression
- [ ] Excessive Energy
- [ ] Fatigue
- [ ] Guilt
- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability

- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Relationship concerns
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Has the client ever tried the following?

(check all that apply)

- [ ] Alcohol
- [ ] Cocaine
- [ ] Ecstasy
- [ ] Marijuana
- [ ] Hallucinogens (LSD)
- [ ] Heroin
- [ ] Methamphetamines
- [ ] Methadone
- [ ] Pain Killers
- [ ] Stimulants (Pills)
- [ ] Tobacco/Nicotine
- [ ] Tranquilizers

If yes to any, list frequency/dates of use:

List current illicit drug use:

Has the client ever been treated for drug/alcohol abuse? If yes, when?:

Pertinent History

Is the client being prescribed any medications for a mental health condition by a Psychiatrist, PsychNP, Pediatrician, and/or a Neurologist? If yes, please provide the following: Prescribers Name, Address, & Phone Number/Fax:

Past medications:

Please list Previous diagnoses/mental health treatment:

Any history of trauma?:

Any past suicide attempts?:

Family History

How is the client's relationship with their family members?:

Family member psychiatric conditions:

Present Situation

Name of School & Current Grade:

Does the client currently have an IEP?:

Does the client currently have a 504 plan?:

Any current suicidal thoughts?:

Is your family a member of a religious/spiritual group?:

Legal

Do you currently or have you ever had CPS/APS involvement? If yes, when and what were the allegations?:

Do you have any current or pending court orders related to custody agreements or legal guardianship? If yes, please provide more information:

Has the client ever been arrested? If yes, when and what were the charges?:

Primary Care Physician

It is very important that I communicate with your primary care physician and your psychiatrist (if you have one) after your consultation. Please take a few moments to provide your doctor's contact information.

Name, Phone Number, Fax Number, Address:

Additional

Are any other member(s) of your family currently seeing another therapist in our practice:

Anything else you would like your therapist to know?:

Suicide & Crisis Lifeline: If your life or someone else's is in imminent danger, please call 911. If you are in crisis and need immediate help, please call: 988

Emergency Contact

Please enter the name, relationship, and phone number your therapist should call in the case of an emergency

Name:

Relationship to client:

Phone Number: