

NICOLE BRESLEND, PH.D.
Psychological Trainee (Rostered Psychotherapist)

INTAKE INFORMATION

Client's Information:

Last Name: _____ First Name: _____ M. I.: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

Date of Birth: _____ Gender identity: _____ Pronouns: _____

Marital Status: S M D W CU

Employer: _____ Occupation: _____

Insurance Provider: _____

Person Completing Form: _____ Date: _____

Referring Physician

Name: _____

Person to Contact In Case of an Emergency:

Name: _____ Relationship: _____ Tel: _____

Contact Information for Clients under 18 years of Age:

Parent/Guardian: _____

Home Phone: _____ May I leave a message at this number? Yes No

Cell Phone: _____ May I leave a message at this number? Yes No

Work Phone: _____ May I leave a message at this number? Yes No

Email: _____

Additional Parent Guardian: _____

Home Phone: _____ May I leave a message at this number? Yes No

Cell Phone: _____ May I leave a message at this number? Yes No

Work Phone: _____ May I leave a message at this number? Yes No

Email: _____

Additional Parent Guardian: _____

Home Phone: _____ May I leave a message at this number? Yes No

Cell Phone: _____ May I leave a message at this number? Yes No

Work Phone: _____ May I leave a message at this number? Yes No

Email: _____

Family Information:

Child/Teen's primary residence:

Single Parent Home Two Parent Home Other:

Within the primary residence, child/teen is living with:

Both Biological Parents Biological Father Biological Mother
 Stepfather Stepmother Other:

Marital Status of Primary Caregiver(s) (if under 18):

Married Separated Widowed/er
 Divorced Single

*If divorced who has custody?

Mother Father Joint Custody
 Neither Specify: _____

School Information:

Name of School: _____ Grade: _____ Teacher: _____

Type of school: Public Private Special _____

List previous schools, dates attended, and indicate performance (academic and behavioral):

_____ Performance: Poor Fair Good
_____ Performance: Poor Fair Good
_____ Performance: Poor Fair Good

Grades repeated: _____ Grades skipped: _____

Reasons for repeat/skipped: _____

Has your child ever been suspended? No Yes

Has your child ever been expelled? No Yes

Does your child/teen have an IEP/504 Plan or receive any special programs: No Yes

If yes, explain: _____

Reason for Referral

Please take a moment to explain the reasons you/your child/your teen are seeking psychological support. What concern(s) is/are bringing you and/or your child/teen into care?

Goals for Treatment:

Please explain what you are hoping to gain from treatment.