

NICOLE BRESLEND, PH.D.
Supervised Psychological Clinician

INTAKE INFORMATION

Client's Information:

Last Name: _____ First Name: _____ M. I.: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone: _____
Date of Birth: _____ Gender: M F Other Marital Status: S M D W CU
Employer: _____ Occupation: _____
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's primary residence:

Single Parent Home Two Parent Home Other:

Within the primary residence, child is living with:

Both Biological Parents Biological Father Biological Mother
 Stepfather Stepmother Other:

Other Children (living with this child):

Name and Age: _____

Name and Age: _____

Name and Age: _____

Name and Age: _____

Other relatives or persons living in the home:

This child has how many total: _____ older siblings _____ older half-siblings
 _____ older half-siblings _____ younger half-siblings
 _____ older stepsiblings _____ younger stepsiblings

Is this child adopted? Yes No

If yes, please describe the circumstances of the adoption: _____

Marital Status of Primary Caregiver(s):

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: _____

Suspended? No Yes

Expelled? No Yes

Any known learning disabilities? No Yes

If Yes, when was testing completed and explain specific disabilities (Please provide copies of testing if possible): _____

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

If yes, explain: _____

Which of the following problems, if any, does this child have in school?

- Does not do homework
- Starts but does not finish homework
- Fails to check homework
- Poor handwriting
- Poor Spelling
- Poor reading skills
- Forgets assignments
- Messy and disorganized
- Does not remain seated
- Incomplete classroom work
- Poor attention in class
- Non-compliant in class
- Talks out excessively in class
- Poor math
- Distracted
- Test Anxiety
- Makes many careless errors
- Excessive time to complete assignments
- Problems with written language

Further comments on homework, academic functions: _____

Psychosocial Functioning:

Which of the following, if any, describe(s) this child's interactions with peers?

- No friends
- Few friends
- Trouble keeping friends
- Mean, aggressive
- Too shy or too timid
- Trouble making new friends
- Bossy, controlling
- Risky behaviors

Extracurricular/Group Activities: _____

Further comments on peer functioning _____

Reason for Referral

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

Goals for Treatment:

Please explain what you are hoping to gain from treatment.