Sharon Fischer Therapy

First Appointment Intake Form

Client's name: _____ Date: _____

Date of Birth: _____/_____/_____

Address: _____

_____

Best Phone Number:_____

Parent/Guardian's Names:_____

Siblings Names and Ages:_____

Primary Care Physician's Name, Address & phone #: _____

_____

Do I have permission to speak to the doctor? Yes No

Parent/Guardian's Signature:_____

Family History

Please list any family members with a history of mental illness : _____

_____

_____

_____

Please list any family members with a history of substance abuse issues: _____

_____

_____

Medical History

Please list any medical concerns (past or present):_____

_____

Please list any medications: _____

_____

Dose: _____

Mental Health History

Ever been to see a therapist before? (Please circle one) Yes No

If yes, please describe the reason for ending therapy: _____

_____

_____

_____

Therapist's Name: _____ Phone: _____

Name: _____ Phone: _____

Do I have permission to speak to former therapists? Yes No

Parent/Guardian's signature: _____

History of hospitalizations for mental health concerns? (Please circle one) Yes No

History of suicidal attempts: (Please circle one): Yes No

If yes, please describe: _____

_____

_____

History of substance abuse issues: _____

_____

Child Developmental History

Please describe any complications during pregnancy or birth: _____

_____

_____

_____

Age child spoke his/her first words: _____

Age child started walking: _____

Age child was potty trained: _____

Please describe any separation issues child experienced: _____

_____

_____

Sleep concerns (past or present): _____

Behavior concerns (past or present): _____

_____

Eating concerns (past or present): _____

_____

Developmental delays? (Please circle one): Yes No

If yes, please describe: _____

_____

_____

Has your child/teen received any testing either in school or outside of school?

(Please circle one): Yes No

***If yes, please bring a copy of the report to the first appointment**

Social History

Does child/teen have friends? (Please circle one) Yes No

Child/Teen's extracurricular activities/interests: _____

_____

_____

Does child/teen struggle in school? (Please circle one) Yes No

If yes, please describe: _____

_____

_____

Child/Teen's strengths (what is he/she good at?): _____

_____

_____

_____

Daily intake (Yes/No and how much):

Caffeine: _____

Nicotine: _____

Alcohol: _____

Drugs: _____

Trauma History

Child/Teen experienced anything traumatic, life threatening, or scary (Please circle one):

Witnessed violence Death of a close friend or relative A Natural Disaster

Sexual abuse Physical abuse Rape Flood Fire

Verbal Abuse Domestic Violence Other:_____

What to address in therapy

Parent/Guardian:

Please briefly describe your reasons for seeking help for your child/teen: _____

What will be different in your life when you and your child/teen are finished with therapy? _____

Child/Teen:

Please briefly describe your reasons for seeking help: _____

What will be different in your life when you are finished with therapy? _____

Please check mark ONLY those items that are of personal concern to you currently.
If any of your concerns are not listed, please write them in the "OTHER" space at the end.

Abuse Issues
_____ Emotional abuse
_____ Physical abuse
_____ Sexual abuse

Control Issues
_____ Alcohol (beer, wine, or liquor)
_____ Cocaine, speed, ecstasy, substance abuse
_____ Eating Disorder
_____ Gambling
_____ Internet addiction
_____ Marijuana use

Emotional Concerns
_____ Anger
_____ Anxiety, Nervousness
_____ Depression
_____ Guilt
_____ Isolation, withdrawal
_____ Mood swings
_____ Self-control
_____ Suicidal thoughts
_____ Worry
_____ Stress

Social or Performance Concerns
_____ Decision making or setting goals
_____ Difficulty concentrating
_____ Lack of assertiveness
_____ Lack of motivation
_____ Loneliness
_____ Memory problems
_____ Prejudice
_____ Public speaking anxiety
_____ Shyness or discomfort in social settings

Violence Issues
_____ Date rape
_____ Relationship violence
_____ Sexual assault
_____ Stranger rape

Life Circumstances
_____ Work
_____ Credit card debt
_____ Death, grief, loss, separation
_____ Financial matters
_____ Housing
_____ Illness of someone close
_____ Legal problems
_____ Life transitions (Leaving home relationship changes,

Personal Issues
_____ Body Image
_____ Concern about coming out
_____ Confusion about values morals, and/or beliefs
_____ Cultural conflict/adjustment
_____ Sexual concerns
_____ Loss of faith in my religion or religious uncertainty
_____ Self-esteem/self confidence

Relationship Issues
_____ Family members (parents siblings, etc.)
_____ Interracial dating
_____ Interreligious dating
_____ Parenting concerns
_____ Partner/spouse
_____ Peer Relationships
_____ Relationship breakup or divorce
_____ Sex

_____ **Academic Concerns**

_____ **Career Concerns**

_____ **Health Problems**

_____ **Sleep Problems**

_____ **Other**

_____