Susan E. D'Esposito, Ph.D.

Phone: (516) 456-1155
E-Mail: SusanElainePhD@gmail.com
DrSusanElaine.com

Child/Adolescent Intake Form

Contact Information:

Name of Child: _____ Childs Date of Birth _____

Name of Parent(s) or Guardian: _____ Age _____

_____ Gender _____

Address: _____

_____

_____

Primary Number:_____ Work Number:_____

Is it OK to leave a detailed message? Yes **O** No **O** Is it OK to leave a detailed message? Yes **O** No **O**

Is it OK to Text appointment information? Yes **O** No **O**

(If not, a message with only contact and appointment information will be left on preferred method of communication)

Email Address:_____

Preferred method of communication: Home **O** Work **O** Cell **O** Text **O** Email **O**

Guardian Information:

Guardian #1: _____ Guardian #2: _____

Relationship to client: _____ Relationship to Client: _____

Do you have legal custody? _____ Do you have legal custody? _____

Cell Phone: _____ Cell Phone: _____

Is it OK to leave a detailed message? Yes **O** No **O** Is it OK to leave a detailed message? Yes **O** No **O**

Is it OK to Text appointment information? Yes **O** No **O**

(If not, a message with only contact and appointment information will be left on preferred method of communication)

Clients' Cell Phone: _____ Clients' Email: _____

Referred by:_____

Siblings:

Name:	Age:	Gender:

School: _____ Grade: _____ Does this child have an IEP? _____

(If yes, Please include their most recent IEP and any psychological/educational testing reports.)

Does this child have any disabilities? Yes **O** No **O**

If yes, Please explain _____

_____

_____

School History: (i.e. schools attended, grades repeated etc.)

_____

_____

_____

_____

Do you have any concerns regarding performance in school? Yes **O** No **O**

_____

_____

Primary Reason for Seeking Therapy:

_____

_____

Presenting Problems and/or Concerns:

_____

_____

_____

_____

Behavioral History/Concerns:

_____

_____

_____

_____

Family history of mental health:

_____
_____
_____
_____

Family history of medical concerns:

_____
_____
_____
_____

Has this child had prior psychotherapy? Yes **O** No **O**

If yes, with who:_____

For how long:_____

For what concerns:_____

Has this child ever been prescribed any psychiatric medications? Yes **O** No **O**

If yes, please list:

_____
_____
_____
_____

List any significant developmental delays (potty training, eating, sleeping, walking, talking) including problems with pregnancy, labor, birth, etc.

_____
_____
_____
_____

List any significant medical problems/history of client (child):

_____
_____
_____
_____

Please list current medications of client (child):

_____
_____
_____
_____

Allergies of client(child):

_____
_____
_____
_____

Does the client/child have any concerns about the use of alcohol or drugs? Yes **O** No **O**
If yes, Please describe:

_____
_____
_____
_____

How often does the client/child drink alcohol and how much do you typically drink?

_____
_____
_____

Does the client/child smoke/vape/use cigarettes and/or nicotine products (if yes, how often)?
Yes **O** No **O**

_____
_____
_____
_____