Outpatient Intake Form

Please complete to the best of your ability.

General Information:

Name: _____ Gender: Male / Female

Address: _____ DOB: _____

City: _____ State: _____

How long have you lived at this address: _____ Phone Number: _____

Marital Status: _____

Emergency Contact Information:

Emergency Contact's Name: _____

Address: _____

Phone Number: _____

Relationship to you: _____

Presenting Problem:

Recent Stressor(s) - Main reasons you are seeking services?

_____

_____\

Chief Complaints:

(Check all symptoms below that help explain problems that your child is experiencing at the present time).

- □ Aggressive or violent behavior
- □ Argumentative
- □ Complaints behavior
- □ Cruelty
- □ Drug Use/Alcohol Use/Tobacco Use
- □ Eating problems (Not eating enough/Overeating)
- □ Fatigue/feeling tired/lack of energy
- □ Feeling detached from body
- □ Hopelessness
- □ Hyperactivity (Full of energy all day long)
- □ Inappropriate sexual behavior
- □ Loss of a loved one, Loss of a relationship
- □ Mood swings
- □ Anger issues
- □ Bladder or bowel control problems
- □ Criminal behavior
- □ Depression, Sadness or feeling down
- □ Easily Distracted
- □ Fear of "going crazy"
- □ Fear of losing control
- □ Flashbacks
- □ Housebound (Does not want to leave the house)
- □ Identity issues (Confusion about who your child wants to be)
- □ Impulsive behavior (Does not think before acting)
- □ Lying
- □ Nervousness (Worrying)

- □ Nightmares
- □ Panic Attacks
- □ Poor grades
- □ Poor relationships with other children/peers
- □ Problems remembering things
- □ Relationship or family conflict
- □ Trauma (please specify): _____
- □ Obsessive thoughts
- □ Self-harm such as cutting/burning self
- □ Numerous physical complaints (Complains about feeling sick)
- □ Paranoia (Extreme fear or distrust of others)
- □ Poor hygiene
- □ Problems concentrating
- □ Irritability (Often acts miserable and complains a lot)
- □ Developmental Delays (delays in learning, growth, speech, social)

Mental Health History:

1). Have you had counseling services before? (If yes, please list when and for what reasons).

_____

_____

2). Have you ever been hospitalized for mental health problems before? (If yes, please list where and when).

_____

_____

3). Have you ever been diagnosed with a mental health condition? (If yes, list the diagnosis/diagnoses).

_____

_____

4). Have you ever stated in the last year that you want to kill themselves? (If yes, do they have a plan and what is the severity of their suicidal ideation, please explain.)

_____

_____

5). Have you stated that you want to harm or threaten someone else? (If yes, please explain):

_____

_____

Brief Family History:

1). Do you have any family members who suffer from mental health problems? (If yes, please explain):

_____

_____

2). Do you have any family members who suffer from drug and/or alcohol problems? (If yes, please explain):

_____

_____

3). Do you have any family members who have committed suicide? (If yes, please explain):

_____

_____

4). Are there any concerns regarding family members (either living or deceased) that may be impacting you at the present time? (If yes, please explain).

_____

Personal and Family Medical History:

1). Do you have any current medical conditions? (If yes, please list all current medical conditions).

_____

2). How many hours of sleep do you get per night?

_____

3). Do you think that you have healthy eating habits? If no, please explain.

_____

4). Do you take any medication(s)? (If yes, please list medication name(s))

_____

Social Relationships:

1). How well do you get along with other people (friends, coworkers, etc.)?

_____

_____

2). Do you make friends easily? (Please explain).

_____

_____

Development:

1). Did you walk, talk, toilet train, etc. at the correct developmental times? (If no, please explain).

_____

_____

2). Did/Do you receive speech therapy, occupational therapy, physical therapy, etc.? (If yes, please explain).

_____

_____

3). Did you have any exposure to drugs, alcohol or tobacco use by your mother during pregnancy?

_____

4). Was there any domestic violence between your mother and any other parties when your mother was pregnant with you? (If yes, please explain).

_____

_____

Living Situations:

1). Who do you live with currently? Please list ALL household members:

_____

_____

2). Is there anyone living in your household who has a drug/alcohol problem? (If yes, please explain).

_____

_____

Trauma History:

1). Have you ever been physically, sexually, or emotionally abused? If yes, please explain.

_____

2). Have you ever witnessed any type of traumatic events in your life? (For example, been involved in a natural disaster, witnessed domestic violence, watched someone they care about die, witnessed drug and alcohol use in the home, etc. If yes, please explain).

_____

_____

Strengths:

1). What do you enjoy doing for fun?

_____

_____

2). Who/What do you have in your life that provides you with support and hope?

_____

_____

Daniel Trauma Center & Associates Intake

I verify all information is truthful to the best of my knowledge (please sign below):

:_____ Date: _____

STAFF USE ONLY:

I verify I reviewed the above information:

_____ _____

Signature Date