OZ THERAPY

CHILD/ADOLESCENT INTAKE FORM

Name: ______________________________ **Today's Date:** ____________

Date of Birth: _____/_____/_____ **Sex:** M F

Race: ________ **Preferred Language**: ____________________

Address: ____

Phone #: ______________________ **Email**:________________________

May we leave reminders of your appointments at this number? Y N

Name of person completing this form: ________________________________

Relationship to Patient:____

Please describe the present problem (when the problem started, how often it occurs, what stressors may contribute to the problem, etc)**.**

Has your child received any previous treatment for the problem? If yes, explain.

Name of Pediatrician or Family Doctor: ________________________

Date last seen: ______________________________________

Please circle any of the following medical conditions your child has been diagnosed with (if any)**.**

Seizures	Heart Problems	Weight Problems	Head Injury
Asthma	Chronic Fatigue	Chronic Headaches	Depression

Hearing Loss　**Stomach Issues**　**Suicidal Thoughts**　**Surgeries**
Other ____

Please explain any item circled and how it was treated.

List any medications your child has been prescribed.

Birth weight: ____________________ **Was this a full term birth?** **Y** **N**
If no, please explain.

Were there any complications with labor & delivery? **Y** **N**
If yes, please explain.

Please circle the following items that apply to the patient's toddler years.

Discontented	**Restlessness**	**Feeding Problems**	**Sensitivities**
Sleep Problems	**Fussy or Colic**	**Difficulty Bonding**	**Head Banging**

Please indicate the approximate age your child achieved the following tasks:
Sitting alone _______ **Walking** ________ **Put words together** ______ **Toilet Trained** _________

Circle any of the following behaviors your child has done or currently does:

Spinning self or objects　**Putting objects in mouth**　**Repeating words/phrases**

Hand flapping	Sniffing excessively	Saying “I” for “You”

What school/daycare does your child currently attend? ______________________________

What is his/her current grade placement? ____

Has he/she ever repeated a grade? If so, why? ______________________________________

Has he/she ever been evaluated for a learning disability? Y N

Does your child have a current IEP/504 plan? Y N

Does your child struggle with learning at school, have behavior issues, or both?
Y N If yes, when did the problems begin?

Has your child ever been expelled or suspended from school or bus? Y N
If yes, why?

Has anyone in your household been involved with DHR? Y N
Who was/is involved? ____________________Caseworker: _____________________

Has your child ever been arrested? Y N If yes, what were/are the charges?

Is your child currently on probation? Y N

Has your child ever been physically, sexually, or emotionally abused? Please explain.

Has any member of your child's family been diagnosed/treated for Depression, BiPolar Disorder, Schizophrenia, Anxiety, Suicidal Ideation, Substance Abuse, Learning Disabilities, ADHD, Autism, Dyslexia, etc? If so, please explain.

Who lives in the home with the patient? Please list all adults and children as well as their ages.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please circle the guardian type who lives with the client and/or shares custody.

Biological Mother	**Biological Father**	**Step Mother**	**Step Father**
Adopted Mother	**Adopted Father**	**Grandparent**	**Aunt**
Uncle	**Other ____________________**		

Please describe the custody arrangement if applicable.

Please circle any of the following that affect your child.

Family Financial Problems	**Family Relationships**	**Legal Problems**
Child Rearing Problems	**Drug/Alcohol Problems**	**Abusive Behavior**
Health Problems	**Employment Problems**	**School Problems**
Peer Relationships	**Frequent Change of Household**	**Frequent Moves**

Please circle any of the following affecting your child:

Family financial issues	**Family relationships**	**Frequent change of household**
Child rearing issues	**Drug/Alcohol struggles**	**Abuse behaviors**
Health issues	**Employment issues**	**School issues**
Peer relationships	**Legal issues**	**Frequent moves**

Is there anything else you would like to share?

Parent/Guardian/Client Signature: ____

Counselor Signature: ____

Diagnosis Code: ____

For office use only:

Date added to billing spreadsheet: __________________________ Initial: _________