Lauren Pellizzi LLC

55 Route 35, Suite 5
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CHILD / ADOLESCENT INTAKE FORM

Note: This information is confidential.

DEMOGRAPHIC INFORMATION			
Name of person completing this form:	Relation to child		
Phone:	Email:		
Check all methods of communication which are acceptable. ☐ Phone ☐ Email ☐ Text message Preferred contact method:			
Name of other parent/legal guardian:	Relation to child:		
Phone:	Email:		
Child's Name:	DOB:	Age:	☐ M ☐ F ☐ Other
Home Address:			
Religion	Sexual Orientation:		
How much does religion affect your daily life? (None) 0 1 2 3 4 5 (Very much)			
Referral Source:	May I thank them? ☐ YES ☐ NO		
Who lives in your household?			
Name	**Relationship**		**Age**
List any other siblings / step-siblings not listed above			
Name	**Relationship**		**Age**

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EMERGENCY CONTACT INFORMATION	
Name:	Address:
Phone:	
Relationship to client:	

INSURANCE	
If you plan on submitting claims to your insurance company, please complete the information below.	
Name of policy holder:	Policy holder date of birth:
Name of Insurance Company:	
Policy #:	Group #:
Provider Services phone # for mental health/substance abuse services:	

EDUCATION	
Name of school:	
IEP or 504 plan in school? ☐ YES ☐ NO	Grade:

Check all that apply: ☐ I'm involved in extracurricular activities ☐ My behavior gets me into trouble in school

☐ Academic performance is average ☐ I have no friends in school ☐ I get bullied in school

☐ Academic performance is above average ☐ Academic performance is below average

☐ My grades have dropped recently ☐ My attendance is poor ☐ School makes me anxious

MEDICAL HISTORY	
Primary Care Physician:	Phone:
Psychiatrist:	Phone:
Current medical conditions (asthma, diabetes, etc.):	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Name the Drug	Strength	Frequency Taken

Allergies:

Name	Reaction You Had

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PSYCHIATRIC HISTORY		
Psychiatric Hospitalizations and/or Residential Treatment		
Year	Reason	Hospital
Past outpatient treatment (i.e. therapist, psychiatrist, group therapy)		
Year	Reason	Treatment Provider

FAMILY HISTORY
Is there a family history of mental health problems? ☐ YES ☐ NO
Has anyone in your family ever attempted or completed suicide? ☐ YES ☐ NO
Is there a family history of drug and/or alcohol abuse? ☐ YES ☐ NO
Previous or current involvement with DCP & P (formerly DYFS)? ☐ YES ☐ NO
Has your child ever experienced the following:
Expressed thoughts of suicide? ☐ YES ☐ NO Attempted suicide? ☐ YES ☐ NO
Engaged in self-harm behaviors (cutting, burning)? ☐ YES ☐ NO
Engaged in eating habits which concerned you? ☐ YES ☐ NO
Been a victim of or witnessed sexual abuse? ☐ YES ☐ NO
Been a victim of or witnessed physical abuse or domestic violence? ☐ YES ☐ NO
Suffered a traumatic experience (car accident, natural disaster, other events which were traumatic to your child)? ☐ YES ☐ NO

FAMILY STRESSORS					
	Current	Past		Current	Past
Marital Problems			Housing Problems		
Marital Separation			Legal Issues		
Divorce			Death of a friend		
Custody disputes			Death of a Relative		
Financial Problems			Death of a pet		
Job Loss			Family illness		
Parent using alcohol/drugs			Moved to new area		
Changed schools			Other:		