Slater & Associates, LLC

Therapeutic Supervised Visitation Intake Form

Patient's Name: ____DOB: ___________Age:__________
First Middle Last

Address: ____ City: ________________ Zip:_________

E-Mail Address: ____

Occupation: ____ Employer:___________________________

Education Level (circle one): HS Bachelor Master Doctorate

Number of Marriages: _________________________ Gender (circle one): M F

Relationship Status (check one) ____Single _____ Married _____ Divorced ____Committed Relationship

Home Phone: ________________________________ OK to leave message? Y N
Cell Phone: ________________________________ OK to leave message? Y N
Work Phone: ________________________________ OK to leave message? Y N

Family Information (If a minor or a family):

Mother: ____ Phone: _____________________

Address: ____ City__________________Zip_________

Father: ____ Phone: _____________________

Address: ____ City__________________Zip_________

Parent's relationship status (circle one)

Married Divorced Never Married

Current Custody (circle one): Joint Sole Split

Current Timesharing Arrangement:
Mother: **Father:**

Please list below all family members living in the household:

Name	Age	Gender	Relationship

Medical History (Patient):

Current Health Problem	Treating Physician	Medication

Date of last physical examination: ______________________ **Physician:**____________________

List previous care by a mental health professional:

Treating Practitioner	Dates	Family Member & Reason

Who referred you?

_________ Doctor / Psychiatrist
_________ School
_________ Friend
_________ Internet

______ Mental Health Professional
______ Court (Specify) ___________________
______ Employer
______ Attorney
Name: ____________________________

Briefly describe the reason for seeking help:

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What do you hope will change for you and/or your child by participating in TSV?

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