

## Intake Form

CHILD NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

GENDER IDENTIFICATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE(S): \_\_\_\_\_

CAN DR. KUZIRIAN LEAVE A MESSAGE? YES/NO

D.O.B.: \_\_\_\_\_ AGE: \_\_\_\_\_ GRADE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

REFERRAL BY: \_\_\_\_\_

PARENT'S MARITAL STATUS: \_\_\_\_\_

PERSON(S) W/ LEGAL AUTHORITY TO MAKE MEDICAL DECISIONS FOR CHILD:

PARENT OCCUPATION(S): \_\_\_\_\_

WHY DID YOU SCHEDULE APPOINTMENT? \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

PHONE: \_\_\_\_\_ LAST EXAM: \_\_\_\_\_

PAST/PRESENT MEDICAL CARE (Specify: major problems, current medication):

PSYCHIATRIST: \_\_\_\_\_ Phone: \_\_\_\_\_

MOST RECENT APPOINTMENT: \_\_\_\_\_

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/MENTAL HOSPITALS:

1. Therapist: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_ Phone: \_\_\_\_\_

2. Therapist: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_ Phone: \_\_\_\_\_

REASON FOR PREVIOUS TREATMENT: \_\_\_\_\_

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE:

*Use the space below and on the back of this form if you need to give further information.*