Deborah Essex, MFT
2931 Shattuck Avenue, 101E
Berkeley, CA 94705

Initial Intake Form

Child Information:

Last Name_______________ First Name _______________ Middle _________

Telephone: home _________________
work _________________
parent cell phones _______________ _______________
parent e-mails ___________________ ______________________

Address ____
____

Age_______ Birth Date ___/___/______

School____________________________ Grade _____ Teacher _______________

Other schools recently attended: ____

Living Situation, lives with ___ Immediate Family
___ Extended Family
___ Foster Family
___ Other:

Names of Others in Home:

Name _______________________________ Age____ Relation _______________
Name _______________________________ Age____ Relation _______________
Name _______________________________ Age____ Relation _______________
Name _______________________________ Age____ Relation _______________

Reason for Seeking Treatment:

____

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List problems at home (if applicable):

List problems at school (if applicable):

List problem with family members (if applicable):

List problems with peers (if applicable):

Check if any of the following as been a problem in the last 6 months. Make additional comments, where applicable:

___ problems with anger (please specify: holds it in, out of control, hitting or hurting others, etc.):

___ problems with fears/anxieties

___ problems with activity level:(Hyperactivity/ inactivity)

___ problems with eating (Weight gain/ weight loss)

___ problems with sleep (insomnia, night wakings, nightmares, over-sleeping)

___ problems with concentration, or memory

___ problems with completing tasks

___ problems with mood (please specify, depressed, angry anxious, flat):

___ communication problems (please specify):

___ other problems with behavior (please specify)

Family History (include any significant or difficult events, such as change in living circumstances, illnesses or death of family members, change in schools, separation or divorce):

____

____

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Describe your relationship to your child. Have there been changes in the last 6 months?

____

____

____

History of significant caretakers (including day care, grandparents, etc.). Was child's relationship positive with caretakers?

____

____

What do you see as your child's major strengths and weaknesses?

____

____

____

Medical History:
Significant or unusual medical history including major illnesses, injuries, hospital stays, diseases or disabilities during pregnancy, birth, infancy and preschool development:

____

____

____

Primary Care Physician: __________________________ Location _______________

Current Medications: ____

Emergency Contact:
Name ______________________________ Telephone (cell #s)_________________

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Mental Health History:
Prior treatment with mental health practitioner (Reason for seeking help, name of provider, dates/ frequency seen, response to treatment):

____

____

Psychiatric Medication, if prescribed (type, date first taken, dosage, response, side effects):

____

List other close family members involved in mental health treatment (incl. reasons):

____

Family/genetic history of mental illness (e.g.; depression, ADHD, anxiety, addiction,etc.):

____

____

Therapeutic Goals:
What are you (and/or your child) seeking to improve with therapy?

____

____

____

What are your family's major <u>strengths</u> (i.e. we like to spend time together, parents communicate well with each other, we try to solve our problems, we have a network of family and friends to provide support) and <u>weaknesses</u> (parents/children often disagree, poor communication, we have very little time to spend together, we lack resources)? How will your family's major strengths or weaknesses affect therapy?

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