LINDA FOLTZ, PH.D.

LICENSED PSYCHOLOGIST

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CHILD AND ADOLESCENT INTAKE FORM

This information and all communications with your therapist, will be kept confidential to the full extent of Georgia Law.

CLIENT INFORMATION Today's Date ____________________________

Child's Name ____ Date of Birth _________________ Age________

Home Address ____

City, State & Zip ____

Home: 770 404 678 _____________________________ Cell: 770 404 678 _____________________________

Child lives with: both biological parents _______ mother _______ father _______

mother & stepfather _______ father & stepmother _______ other: _______________________

If parents are divorced, describe custody arrangements: ____

____

IN CASE OF EMERGENCY, NOTIFY: ____

Relationship: ____ Phone #:_____________________

Medication(s) child is currently using: ____

Previous Counseling/Therapy for child? Yes No If yes, when? ____

Where and with whom? (Please list all) ____

____

____

FAMILY MEMBERS

List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime:

Name	Relationship to Child	Age	Highest School Grade completed	Occupation

INFORMATION ABOUT CHILD'S MOTHER (or current female guardian):

Name ____ Age _______ Race ______________

Employer ____________________________________ Occupation __________________ Hrs/wk _____

Can you be contacted at work by phone? Yes No Work phone: (_____) _________________ ext: _________

Denomination ___________________ Church: _________________________________ Active? Yes No

Describe any physical or emotional problems you have that require medication or physical care: ______________

____

Are you currently receiving medical treatment? Yes No Physician: _______________________________

Medication(s) currently using: ____

Previous Counseling/Therapy? Yes No If yes, when? _____________________________________

With whom and for how long? ____

INFORMATION ABOUT CHILD'S FATHER (or current male guardian):

Name ____ Age _______ Race ______________

Employer ____________________________________ Occupation __________________ Hrs/wk _____

Can you be contacted at work by phone? Yes No Work phone: (_____) _________________ ext: _________

Denomination ___________________ Church: _________________________________ Active? Yes No

Describe any physical or emotional problems you have that require medication or physical care: ______________

____

Are you currently receiving medical treatment? Yes No Physician: _______________________________

Medication(s) currently using: ____

Previous Counseling/Therapy? Yes No If yes, when? _____________________________________

With whom and for how long? ____

CLINICAL INFORMATION

Describe the problem. If possible, list questions for which answers are sought: _________________________

____

____

____

Problem Areas: In the following list, place a check mark next to each item which identifies an area of concern to you. Place **2** checks by those items which are most important. (You may add written comments after areas checked.)

1. _____ Anger/Temper
2. _____ Depression
3. _____ Education
4. _____ Family Problems
5. _____ Fearfulness
6. _____ Marital Problems
7. _____ Physical Problems
8. _____ Problems with Social Relationships
9. _____ Problems with Children
10. _____ Religious/Spiritual Concerns
11. _____ Sexual Concerns
12. _____ Thoughts of suicide
13. _____ Trouble making decisions
14. _____ Unhappy most of the time
15. _____ Use of Alcohol
16. _____ Use of Drugs
17. _____ Work
18. _____ Worry
19. _____ Other (specify): ____________________________________

MEDICAL HISTORY

List child's sicknesses, operations, and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious: ____

____

____

Have there been any previous psychological, psychiatric, neurological, or EEG evaluations? Yes No

If so, please list names, addresses, and dates of contact: ____

____

Indicate any continuing medication or treatment: ____

____

____

How is child's vision? ____

How is the child's hearing? ____

Describe previous speech or hearing therapy, if any: ____

____

When did your child last have a physical examination? ____

Name of Physician: __________________________ Address: ____

____

ACADEMIC/SCHOOL INFORMATION

Name of School ____________________________________ Grade ______ Teacher __________________________

List previous schools attended with dates: ____

____

Has child ever repeated a grade? yes no If so, when? ____

How does your child get along at school? ____

____

Describe difficulties in learning at school: ____

____

Have other family members had learning difficulties? ____

____

Describe what your child likes to do for fun, special interests, hobbies, etc. ________________________________

____

Describe your child's religious background (religious denomination, is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.)

I learned about Dr. Linda Foltz from: ____

I declare that I am the custodial parent or legal guardian of the child or adolescent described in this document and that I have the legal authority to bring him or her for psychological treatment.

Signature: ____