Kelly Brey Love PhD PC
LICENSED PSYCHOLOGIST

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INTAKE INFORMATION-YOUTH (AGE 18 AND YOUNGER)

Date: _____

Demographic Information:

Individual completing this form (name/relationship to patient): _____

Patient's name: _____ Nickname/Preferred name: _____

Date of birth: _____ Age: _____ Gender: _____

Who referred you to Dr. Love/how did you hear about our office? _____

Primary reason you are here today: _____

_____

_____

(congrats- getting here is the first step!) ☺

Family Information:

Biological parents are: Never Married Married Engaged Separated Divorced Widowed

Parent/Caregiver Name: _____ Parent/Caregiver Name: _____

Biological Adoptive Step Foster/Legal Guardian Biological Adoptive Step Foster/Legal Guardian

Home/cell phone: _____ Home/cell phone: _____

Work phone: _____ Work phone: _____

Email address: _____ Email address: _____

Place of employment: _____ Place of employment: _____

Occupation: _____ Occupation: _____

Does anyone else live in the patient's home? (siblings, grandparents, etc). YES NO (If yes, please complete below)

Name	Age	Relationship to patient
Name	Age	Relationship to patient
Name	Age	Relationship to patient
Name	Age	Relationship to patient

Other support systems: (extended family, church, etc) YES NO (If yes, please complete below)

Name	How often seen?	Relationship to patient
Name	How often seen?	Relationship to patient

School Information:

School name: _____ School grade: (if summer, what grade child will be entering): _____

Has the patient been suspended or expelled? YES NO Please explain _____

Has the patient ever received special education services, early intervention, or been retained a grade? YES NO

If yes, please explain: _____

Please list any extracurricular activities the patient is currently involved in: _____

_____

Medical and Developmental History:

Pregnancy complications? YES NO Birth weight: _____ Length of pregnancy: _____

Problems with delivery? YES NO Drug/alcohol/tobacco or prescription medication use during pregnancy? YES NO

Biological mother experience any abuse during pregnancy? YES NO

If "YES" to any of the above questions, please explain here: _____

_____

Medical Information:

Who is the Primary Care Physician (PCP)? _____ Phone: _____

May I share information pertinent to your treatment with the PCP? YES NO

Any hospitalizations, surgeries, or emergency room visits? YES NO

If yes, please briefly describe:

_____

Previous medical diagnoses/conditions: YES NO

If yes, please briefly describe:

_____

Current medical diagnoses/conditions: YES NO

If yes, please briefly describe:

_____

Any sexual/menstrual concerns? YES NO

If yes, please briefly describe:

_____

Mental Health History:

Have you ever received mental health care treatment (psychologist, psychiatrist, counselor, etc)? YES NO

Start/end date	Provider name	Reason for treatment	Diagnosis (if known)	Outcome (None, Poor, Fair, Good, Excellent)

Current psychiatric medications	Dosage	Start date	Reason for taking	Prescriber

Family history of mental health concerns/mental health treatment: YES NO

If yes, please briefly describe diagnosis and relationship to you: _____

_____

Significant relevant family medical history? YES NO

If yes, please briefly describe diagnosis and relationship to you: _____

_____

Social Information:

Does the patient have a history of substance use/abuse (including nicotine)? YES NO DK If yes, please describe:

_____

Family members have a history of substance use/abuse (including nicotine? YES NO DK If yes, please describe:

_____

Does the patient have a history of abuse or neglect? YES NO DK If yes please describe:

_____

Does the patient have any current or previous legal concerns, or offender issues? YES NO DK If yes please describe:

_____

Family members have any current/previous legal concerns, or offender issues? YES NO DK If yes please describe:

_____

Spiritual beliefs/orientation: _____

Cultural/ethnic identification or important beliefs: _____