



# PSYCHOLOGICAL SERVICES, LLC

DEDICATED TO EXCELLENCE IN THE INTELLECTUAL, EMOTIONAL AND BEHAVIORAL DEVELOPMENT OF YOUNG PEOPLE

## INTAKE ASSESSMENT - PARENT FORM

\* These questions are intended to help your therapist design a treatment plan for your family. If you are uncomfortable answering any of these questions please leave them blank; they are not mandatory and will in no way affect the quality or type of services you receive.

IDENTIFYING INFORMATION					
Patient Name:			Age:		
Gender:	DOB: / /	Grade:	School:		
Hair:	Eyes:	Height:	Ethnicity:		
Primary Caretaker(s):			Legal guardian(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, specify relation to child:		
Address:		Day Ph#: Evening Ph#: Cell/Pager Ph#:			
Residence: <input type="checkbox"/> Apartment <input type="checkbox"/> House <input type="checkbox"/> Other:			How long at current address?		
Emergency Contact:		Day Ph#: Evening Ph#: Cell/Pager Ph#:			
Relation to child:					
Other Providers Involved With The Family:					
DCF Worker:			Ph#:		
Pastor/Clergy:			Ph#:		
Pediatrician:			Ph#:		
Probation officer:			Ph#:		
Psychiatrist:			Ph#:		
Psychotherapist:			Ph#:		
Date of initial involvement & length of involvement with child/family:					
1.					
2.					
3.					
Do you feel it would be important for your Arété clinician to contact any of these providers? If so, who: _____					
<b>Note:</b> a formal release of information will need to be signed prior to any contact with outside agencies.					
FAMILY INFORMATION					
Members	Name	Age	Relation to child	In home?	Occupation/grade
Parents/ Caregivers:				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Siblings:				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Others:				<input type="checkbox"/> Y <input type="checkbox"/> N	

Scott Abbott, Psy.D  
Managing Director  
Adolescent & Young Adult Services

2764 Whitney Avenue  
Hamden, CT 06518  
PH: 203-507-4117

Parents' Status: <input type="checkbox"/> Married                      How Long _____? <input type="checkbox"/> Divorced                        How Long _____? <input type="checkbox"/> Never married Together how long _____? <input type="checkbox"/> Separated                        How Long _____?	If divorced/separated, what is the custody arrangement?
	If divorced/separated, how often does each parent see the child?  Mother: Father:

Are there marital or couples conflicts in the home?  No  Yes, describe:

Are there parent-child conflicts in the home?  No  Yes, describe:

Are there sibling conflicts in the home?  No  Yes, describe:

Who is the child/adolescent closest to and why?

Who does the child/adolescent have most difficulties with and why?

**Family issues - Circle any that apply currently (C) or historically (H):**

Issue:	Bio Parent	Step-Parent	Foster Parent	Sibling	Grand-parent	Aunt/ Uncle	Cousin
Alcoholism	H C	H C	H C	H C	H C	H C	H C
Drug abuse	H C	H C	H C	H C	H C	H C	H C
Emotional Problems	H C	H C	H C	H C	H C	H C	H C
Learning Problems	H C	H C	H C	H C	H C	H C	H C
Legal Problems	H C	H C	H C	H C	H C	H C	H C
Mental Illness	H C	H C	H C	H C	H C	H C	H C
Retardation	H C	H C	H C	H C	H C	H C	H C

Other:

**PROBLEMS & CONCERNS**

Please check each problem or issue that applies to the child/adolescent and explain:

<b>Emotional Issues</b>	<input checked="" type="checkbox"/>	Please explain any problem or issue that you check
Anxious or worried	<input type="checkbox"/>	
Cries excessively	<input type="checkbox"/>	
Depressed mood or sadness	<input type="checkbox"/>	
Easily frustrated	<input type="checkbox"/>	
Excitable	<input type="checkbox"/>	
Explosive episodes	<input type="checkbox"/>	
Irritable	<input type="checkbox"/>	
Excessively happy and excited	<input type="checkbox"/>	

Overactive		
Mood swings		
<b>Cognitive Issues</b>		
	✓	Please explain any problem or issue that you check
Disorganized		
Impaired perception of reality		
Inappropriate self-touch		
Obsessional thoughts		
Perfectionistic		
Self-destructive thoughts		
<b>Social Issues</b>		
	✓	Please explain any problem or issue that you check
Avoids others		
Blames others		
Bosses peers or siblings		
Bullied by others		
Bullies younger children		
Follows others easily		
Has academic problems		
Intimidates others		
Lacks concern for others		
Overly sensitive		
Shy		
Starts/engages in family conflicts		
Taunts or makes fun of others		
Teases		
Threatens		
Withdraws from others		
Other concerns:		
<b>Behavioral Issues</b>		
	✓	Please explain any problem or issue that you check
Abuses alcohol		
Frequency/Last Known Use		
Abuses drugs		Type:
Frequency/Last Known Use		
Aggressive		
Braggs or boasts		
Cheats on schoolwork		
Denies wrongdoing		
Eats too much		
Eats very little		
Engages in repetitive behaviors		
Lies		
Makes noises		
Poor sleep		
Pouts and sulks		
Runs away		
Skips school		
Soils self		
Steals		
Swears		
Tantrums		
Throws or breaks things		
Wets pants/bed		
Whines		

<b><u>Authority Issues</u></b>	✓	Please explain any problem or issue that you check
Argues		
Defiant		
Demands attention		
Impatient		
Makes incessant requests		
Refuses directions		
Refuses work		
Uncooperative		
<b><u>Attention and Activity Issues</u></b>	✓	Please explain any problem or issue that you check
Daydreams		
Fidgets		
Gives up easily on tasks		
Hyperactive		
Impulsive/acts without thinking		
Lacks awareness of surroundings		
Restless		
<b><u>Critical Issues &amp; Experiences</u></b>	✓	Please explain any problem or issue that you check
Caught with a weapon		
Hits/kicks adults		
Hits/kicks children/peers		
Homicidal		
Involved in a gang		
Physically abused others		
Physically victimized by others		
Problematic sexual behavior		
Problematic sexual thoughts		
Promiscuous		
Self-harm or injury		
Sexually abused others		
Sexually victimized by others		
Suicidal		
<b>MEDICAL INFORMATION</b>		
<b><u>Physical Problems &amp; Concerns</u></b>	✓	Please explain any problem or issue that you check
Fever		
Headache		
Digestive difficulties		
Cold-Flu symptoms		
Frequent accidents		
Surgery (past or present)		
Palpitations/heart problems		
Scabies		
Impetigo		
Hypoglycemia		
Eczema		
Fainting spells		
Poor appetite		
Excessive appetite		
Aches/pains		
Rash		
Joint pain		

Skin abrasions or cuts		
Sleep difficulty		
Vision problems		
Physical deformity		
Genetic conditions		
Lice		
Intestinal worms		
Diabetes		
Seizures		
Hernia		
Recent weight gain		
Recent weight loss		
Bruises		
Open sores		
Stiffness		
Recent injury		
Hearing problems		
Asthma/difficulty breathing		
Fetal alcohol syndrome		
Ringworm		
Tuberculosis		
Hay fever		
Frequent ear infections		
Tonsillitis		
Other:		