

INTAKE FORM - CHILD/ADOLESCENT

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GENERAL

Client's Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Client's Personal Phone: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Client's Email: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Siblings/Ages: \_\_\_\_\_

Current living situation, include custody info: \_\_\_\_\_

\_\_\_\_\_

SCHOOL

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Academic strengths and/or struggles: \_\_\_\_\_

Social experiences: \_\_\_\_\_

Please describe your child's strengths: \_\_\_\_\_

DEVELOPMENT:

Please list any complications that occurred during pregnancy or birth: \_\_\_\_\_

Please list any concerns related to your child's development: \_\_\_\_\_

HEALTH:

Please list major illnesses, injuries, or other medical conditions: \_\_\_\_\_

Current Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list all mental health services that your child has/is receiving: \_\_\_\_\_

\_\_\_\_\_

Psychiatrist or Therapist Name/s & Phone: \_\_\_\_\_  
Medications & any side effects: \_\_\_\_\_

**FAMILY HISTORY**

Alcoholism? YES/NO Father / Mother / Sibling / Self / Other  
Treatment?: \_\_\_\_\_

Substance Abuse? YES/NO Father / Mother / Sibling / Self / Other  
Treatment?: \_\_\_\_\_

Mental Illness? YES/NO Father / Mother / Sibling / Self / Other  
Treatment?: \_\_\_\_\_

Serious Illness? YES/NO Father / Mother / Sibling / Self / Other  
Treatment?: \_\_\_\_\_

Any significant deaths? Include approximate dates: \_\_\_\_\_  
\_\_\_\_\_

**INSURANCE (If you will be using a PPO plan, please provide the following:)**

Name of primary insurance holder: \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Primary insurance holder's DOB: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Provider phone # (found on the back of the card:) \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Emergency contact phone: \_\_\_\_\_

How did you hear about my services: \_\_\_\_\_

**PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:**

Name: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_