Stephanie L. Weber, PsyD

Adult Intake

Demographic Information

Client's Name:_____ Date of Birth:_____ Age: _____

Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Gender: _____ Marital Status:_____ Occupation:_____

Employer: _____ Referral Source: _____

Email address: _____

Family & Social History

Individuals residing in the home:

Husband/Wife/Significant Other/Roommate/Other:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation:_____ Employer: _____

Email address: _____

Children in the home:

How many children reside in the home?_____

Name Father Mother DOB Psych concerns?

_____

_____

_____

Is there anyone else that is residing in the home? _____

Family residing OUTSIDE the home:

Mother/Stepmother/Other:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation:_____ Employer: _____

Email address: _____ Years w/child: _____

Relationship with child: _____

_____

_____

Father/Stepfather/Other:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation:_____ Employer: _____

Email address: _____ Years w/child: _____

Relationship with child: _____

_____

_____

Children/Siblings OUTSIDE the home:

How many children reside outside the home? *These include halfsiblings and stepsiblings*_____

Name Father Mother DOB Psych concerns?

_____

_____

Service Information

What type of services are you looking to receive? *Please select*

_____Individual Counseling
_____Family Counseling
_____Relationship/Couples Therapy
_____Co-Parenting
_____ Academic/Achievement Testing
_____ Autism/Developmental Evaluation
_____ Psychological Evaluation
_____ Neuropsychological Testing

What is your reason for seeking services?

Have you seen a psychologist or mental health specialist in the past? If so, please provide information regarding when and who _____

What was the reason for seeking counseling at that time? _____

Health Information

Name of primary care doctor: _____ Phone: _____

Address: _____
City State Zip

Current medical conditions: _____

Previous medical conditions: _____

Operations? _____

Hospitalizations? _____

Head injury/Broken bones? _____

Glasses? _____ Seizures? _____

Current Medications

Name	Dosage	Freq.	Reason	Prescribed by	Helpful?

Sleeping / Eating

Any problems with sleeping? _____

Any problems with eating? _____

Psychological/Psychiatric History

Ever hospitalized?_____

When Where How Long was the stay? Reason

Outpatient follow-up?_____

Helpful?_____

Previous Diagnoses? _____

Substance Abuse History

Any history of substance abuse?_____ Alcohol Abuse?_____

Substance/Drug 1st use Age of regular use Freq. Last use? Problems

Use tobacco products?_____ Packs /day_____

Drink soda/coffee?_____ Cans/cups per day_____

Legal History

Ever arrested?_____

When	For what	Convicted?	Sentence?	Time Served	Probation

Child Protective Services History

CPS History

How many times have you or your family been investigated by CPS?_____

Allegation 1:_____

Allegation 2:_____

What brings you into therapy?