Stephen Ball, Psy.D.

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The Oaks Psychological Group

CLIENT INFORMATION

Name: _____ Date: _____

Home Address:_____

Street City Zip Code

Birth Date:_____

Home Phone #:_____ Work Phone #: _____

Cell Phone #:_____ E-mail: _____

Physician:_____ Phone #: _____

Please describe your living arrangements:

Name: _____ Age:_____ Relationship: _____

In case of emergency, please notify:_____ Phone #:_____

If you would like an invoice provided to you at the end of each month for insurance purposes, please provide the e-mail address where you can receive invoices _____.

Who referred you to my practice? _____
It is customary to thank the referring person. **Your signature below gives me permission to contact and thank this person**. No other information will be disclosed.

Signature:_____ Date:_____

INTAKE INFORMATION

Why are you seeking therapy at this time? _____

_____

_____

Check any symptoms your child has exhibited in the past six months:

___ Sadness/Crying Spells
___ Socially Isolated
___ Appetite/Weight Loss
___ Insomnia
___ Excessive Sleep
___ Giving Up Easily
___ Difficulty Having Fun
___ Excessive Anger/Hostility
___ Suicidal Thoughts/Statements
___ Difficulty with Authority Figures
___ Often in Trouble
___ Argumentative
___ Nervousness/Jittery
___ Irritable/Temper Outbursts
___ Persistent Thoughts
___ Mood Swings
___ Excessive Worrying
___ Fidgety
___ Excessive Nightmares
___ Difficulty Sleeping in Own Bed
___ Very Active
___ Easily Distracted
___ Has Conflicts with Peers
___ Doesn't Follow Directions
___ Other (please describe): _____

List and describe any history of emotional disorder(s) in your biological family:

_____

_____

List and describe any significant life events (e.g. divorce, death in family, etc.):

_____

_____

_____

_____

_____

List and describe your current or historical physical problems (e.g. weight gain, headaches, hypoglycemia, etc.): _____

_____

List any medication(s) and dosage you are currently prescribed: _____

_____

What are your strengths and hobbies? _____