Therapy Intake Assessment

Please indicate who the client(s) are: (parents/child/children)

Parent Name: _____ Date of Birth: _____
Occupation: _____ Educational level: _____
Work Schedule:_____
Address: _____City/State: _____ Zip: _____
Phone: _____ Email address: _____
Individual therapist:_____
Parent's Marital Status:_____

Parent Name: _____ Date of Birth: _____
Occupation: _____ Educational level: _____
Work Schedule:_____
Address: _____City/State: _____ Zip: _____
Phone: _____ Email address: _____
Individual therapist:_____
Parent's Marital Status:_____

Insurance Information: _____
Policy Holder: _____
Member Number: _____
Group Number (Copy of Card): _____
Date of Birth for Policy Holder: _____

**If you are billing a second insurance policy, please complete the following:*
Insurance Information: _____
Policy Holder: _____
Member Number: _____
Group Number (Copy of Card): _____
Date of Birth for Policy Holder: _____

Emergency contact person and phone number:

Please list the name, gender and age of all biological children in your home:

Please list the name, gender and age of all foster and/or adopted children in your home:

What route of adoption did you take? Please check all that apply.

- ☐ Adoption through Foster Care
- ☐ Domestic Private Adoption
- ☐ International Adoption

What are the reasons you decided to adopt?

When did you adopt?

Through what agency did you adopt?

Are you willing to sign a release of information for us to communicate with your adoption agency?

For any of your children, were there any complications during pregnancy, drug or alcohol abuse during pregnancy or any birth complications that you are aware of?

What can you share about your child or children's history of abuse, neglect or trauma?

Briefly describe why you are reaching out for therapy services at this time:

Do/did you have concerns about your child's development in any of the following areas below?

- ☐ Speech/Language
- ☐ Motor Skills
- ☐ Cognitive/Intellectual
- ☐ Sensory
- ☐ Behavioral
- ☐ Emotional
- ☐ Social

Do any of your children have any health issues or take any medication?

Has anyone in your family been in therapy previously? Any previous psychiatric hospitalizations?

Are there any current safety concerns? Is anyone in the home actively suicidal? Has anyone ever attempted suicide?

Do you have concerns about your child in the following areas? (check all that apply)

- ☐ Eating
- ☐ Hygiene/Grooming
- ☐ Sleeping
- ☐ Activities/Play
- ☐ Social relationships

Are there any school concerns for your children related to achievement, peer relationships, behavior or attitude towards school?

Please check if your child has any of the following:

- ☐ Special Education Accommodations or a 504
- ☐ An Individual Education Plan (IEP)
- ☐ Diagnosed Learning Disability
- ☐ Receiving special services at school

Please describe your parenting/discipline style.

On a scale of 1 to 10, how do you feel about yourself as a parent? Please give an explanation for your number.

Are you trained in TBRI (Trust-Based Relational Intervention)? If not, are you open to receiving training?

RECENT SIGNIFICANT EVENTS:

- ☐ Death of family member/friend
- ☐ Change to Health
- ☐ Change in Lifestyle
- ☐ Loss/Change of Job
- ☐ Change in Income
- ☐ Change in Housing
- ☐ Deployment of a Family Member
- ☐ None

Is there a current custody or legal case involving your child (check one)? ____ Yes ____ No
If yes, please describe:

Are there any issues with alcohol or drug use/abuse in your home (parents or children)?

Has there been a history of race-based trauma in your family?

Has there been a history of sexual-orientation based trauma in your family?

Is there a history of violence in your home?

Tell us about your current support system?

What are your expectations of therapy?

What else would you like to share that will help us get to know you better?