**Poyner Psychological Services 14453 SE 29th St. Suite D Choctaw, Oklahoma 73020 405-741-2844 / (Fax) 405-733-1334**

**INTAKE**

**Patient Name: _____ Date of Birth: _____ Age: _____**

**Full Address: _____**

**Phone number: Cell: _____Home: _____ Work: _____**

**Please circle the number(s) above where we can leave a message.**

Please list the name and phone number of a person we can contact if there is an emergency:

**Name: _____ Relationship: _____ Phone Number: _____**

**Please briefly describe the problems you/child are currently having**: _____

_____

_____

_____

**How long have you/child been experiencing the above problems?** _____

**Please check the specific problems you/child are *currently* experiencing**

| | | | | | |
|---|---|---|---|---|---|
| Suicide thoughts/plans/attempts | | Severe anger outbursts | | Hyperactivity/inattention/concentration | |
| Sadness/low mood | | Destruction of property | | Divorce | |
| Sleep problems | | Cutting/animal cruelty/fires | | Marital | |
| Decreased or increased appetite | | Illegal behaviors/substance use | | Parenting | |
| Isolation/not wanting to talk | | Addiction other than substances | | Child's behavior | |
| Little interest in activities | | Excessive/unreasonable fear | | Occupational | |
| Low energy | | Intrusive thoughts of past event | | Childhood problems | |
| Irritability | | Repetitive thoughts or behaviors | | Health/Medical problems | |
| Excessive worry/anxiety | | Highly elevated mood/energy | | Low self-esteem | |
| Argumentative | | Sexual/gender/promiscuity | | Legal | |
| Thoughts of trauma | | Problems with friends | | Are you applying for disability? | |
| Overly stressed | | Family relationships | | Other: | |

Have you/child ever been diagnosed with a mental illness? □Yes □No If yes, please state:

Have you/child ever been hospitalized for your mental health? □Yes □No If yes, how many times and when?

Have you/child received counseling in the past? □Yes □No If yes, when?
Was it helpful? □Yes □No Please explain:

Have you/child ever attempted suicide and/or purposely cut or burned self? □Yes □No If yes, please describe.

Have you/child ever experienced any trauma, such as abuse or other traumatic event? □Yes □No

Do you/child have any serious medical problems? □Yes □No If yes, please state:

Please list *any* medication you/child are currently taking:

| |
|---|
| Have you/child ever abused drugs, prescription medication or alcohol? □Yes □No If yes, please explain. |
| Did you/child have any family problems in your growing up years? □Yes □No If yes, please give a brief description. |
| (Adult) Are you in a romantic relationship? □Yes □No If yes, do you get along? □Yes □No If no, please explain. |
| (Adult) Do you have any children? □Yes □No If yes, are you having any problems with them? □Yes □No If yes, please explain: |
| Are you/child currently involved in a legal matter? □Yes □No If yes, please explain. |
| (Child) Does your child have any developmental or school problems? □Yes □No If yes, please explain.<br><br>What are your child's grades? |
| Is there a family history of mental illness? □Yes □No If yes, please explain. |

What goals do you have for you or your child's therapy? What would you like to change? _____

_____

_____

**Is there any other information you believe we need to know to help you/child in therapy? Please explain below.**

_____

_____

_____

_____

_____

_____

**Please use the back of this form for additional information.**

**FOR CLINICIAN USE ONLY**

The limits of confidentiality were addressed and acknowledged: □ Yes

**Medicaid: I agree with the goals of therapy: Guardian Signature _____ Date: _____**

**Child Signature: _____ Clinician Signature: _____**

| Goals for Therapy | Treatment Plan |
|---|---|
| 1. Decrease:<br><br>2. Increase:<br><br>3. Skill Acquisition: | ☐Supportive ☐Mindfulness ☐PCIT<br>☐Behavior Modification ☐Education ☐CBT<br>☐Medication Referral ☐Desensitization ☐ACT<br>☐Trauma Focused ☐Other: |