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Client intake

Referral Source: *Please take a moment to let me know how you found me.*

Friend: _____ Family Member: _____ PCP: _____

Mental Health Professional: _____ Agency: _____

Support Group: _____ School: _____

Presentation: _____

Print Media: _____ Online (Circle): Psychology Today Meetup.com

Integrated Behavioral Therapy newsletter Eric's Blog Eric's Website

Other: _____

Thank you.

Identifying Information

Date _____

Child's Name: _____ Age/Birthdate: ____/____ Sex: M F

Address: _____ City: _____ Zip: _____

How long at this address? _____

Nickname: _____ Favorite anything _____

Height: _____ Weight: _____

Reason for seeking therapy: _____

Mother's Name: _____ Home Phone: _____

Date of Birth: _____ Age: _____

Email: _____ Cell Phone: _____

Occupation: _____ Business Phone: _____

Employer: _____

Education Completed: _____

Health: ____ Excellent ____ Good ____ Fair ____ Poor

Confidential

Father's Name: _____ Father's Phone: _____

Date of Birth: _____ Age: _____

Email: _____ Cell Phone: _____

Occupation: _____ Business Phone: _____

Employer: _____

Education Completed: _____

Health: _____ Excellent _____ Good _____ Fair _____ Poor

Emergency Contact:

Name: _____ Relation: _____

Phone: _____ Alt Phone: _____

If a parent or legal guardian cannot be reached, I hereby consent that the above named person be contacted. Only relevant information will be shared. This may be changed at any time.

_____ / Parent Signature / Date

Marital Status: Married Remarried Divorced Separated Widowed Single Cohabitants

If Divorced, who has physical custody? _____

Is it full or joint? _____

Who has Legal Custody _____ ? Is it full or joint? _____

Child lives with (circle): birth parents / adopted parents / one parent / other _____

Does either parent's job require him/her to be away from home long hours or extended periods? _____

If married, how long have you been married? _____

If divorced, how long have the biological parents been divorced? _____

Has either parent been married before? Mother: _____ Father: _____

If there are any step parents or step-siblings that have contact with your family please indicate their name and describe the relationship

If the birth parent(s) do not live in the child's home, how much contact does the child have with the parent not having custody, with stepsiblings, etc.?

Other children in the family:

Name	Age/DOB	Sex	School/Grade	Living in home? Y N
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Please list additional siblings in the above format on the back of this page.

Please indicate any special needs of concern regarding the other children living in your home:

Please list any concerns you have regarding the child you are seeking services as it relates to their relationships with these siblings:

Relatives actively involved in my child's and family's life

Name	Relationship	Age	Would this person participate in treatment?
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Friends, Neighbors, Nanny's, Sitters, Tutors, etc involved in my child's and family's life
Please indicate any other people who have a significant role on how this child is raised?
Name Relationship Age Would this person participate in treatment?

Child's race/ethnicity: _____ Religious Beliefs: _____

Languages spoken in home other than English: _____

Other cultural factors: _____

Medical and Behavioral Health Information

Primary Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

How is your child's general health: _____

Does your child have any special medical needs? (circle) Y N

If yes, please describe:

Any Known Allergies (circle) Y N _____

History of Seizures: Y N

If yes, age at time of first seizure and treatment: _____

Age/Date of last seizure and current treatment: _____

Comments: _____

Does your child currently take any medications including those for emotional or behavioral health purposes? Y N

If Yes, please indicate:

Name of Medication:	Dosage	Purpose	How long?

Has your child ever been prescribed any other medications that he/she is no longer taking? Y N

If Yes, please indicate

Name of Medication:	Purpose	How Long?	Reason for discontinuance

Is your child currently involved in any other therapy? (e.g. PT, OT, Speech Therapy, Behavioral Therapy, Mental Health Counseling, Alternative Therapies, etc): Y N

If Yes, Please indicate:

Type:	Provider Name:	Since:	Frequency

Has your child ever received any of the following therapies or supports? If yes please describe:

If yes please provide any relevant information below.

Circle

Evaluation and Therapy History

If any evaluation has been performed, can you obtain and provide a copy? _____

Dates of evaluation or therapy	Type: PT/OT/ST/ABA/Other	Therapist & Location	Results/Recommendations/ Treatment Frequency

Has your child every received any of the following:

- | | |
|---|--------------------------------|
| Y N Applied Behavioral Analysis (ABA) | Y N Play Therapy |
| Y N Cognitive Behavioral Therapy (CBT) | Y N Talk Therapy |
| Y N DIR/Floortime | Y N Developmental Therapy |
| Y N RDI | Y N Listening Therapy |
| Y N Speech Therapy | Y N Life Skill Training |
| Y N Occupational Therapy | Y N Picture Exchange |
| Y N Sensory Integration | Communication Systems |
| Y N Music Therapy | Y N Special Education Services |
| Y N Art Therapy | (IFSP/IEP/504/BIP) |
| Y N Early Intervention | Y N Social Skills Groups |
| Y N Biomedical Treatments (Chealtion, GFCF Diets, DAN Drs. etc) | |

Other: _____

Information regarding previous therapies:

If you or your child has ever received therapy, what was your reason for ending? Were you satisfied? If not, what would have made it better?

Psychological History

Is there a history in your immediate or in the mother's or father's extended family, of any of the following, and if so who? (eg, *Grandma, Uncle, Cousin*)

Yes	No		Who
___	___	Autism Spectrum Disorders	_____
___	___	Learning Problems/Disabilities	_____
___	___	ADD/ADHD	_____
___	___	Depression	_____
___	___	Behavior Problems in School	_____
___	___	Anxiety Disorders (OCD, etc)	_____
___	___	Intellectual Disabilities (MR)	_____
___	___	Psychosis/Schizophrenia	_____
___	___	Substance abuse/Dependence	_____
___	___	Other Mental Health Concerns	_____
		<i>Describe</i> _____	_____

Prenatal and Delivery History:

Did the birth mother receive regular prenatal care? Y N

Were there any complications with the pregnancy? Y N

If Yes, please explain: _____

Was birth at full term? Y N

If no, please explain: _____

Birth Weight: ____ lbs ____ oz

Concerns at birth? Y N

If yes, please provide details- including any treatments given:

Developmental History

Please indicate the age at which your child did the following:

Rolled Over consistently _____

Sat up unsupported _____

Stood _____

Crawled _____

Walked Unassisted _____

Said first word _____

Said 2-3 word phrases _____

Used Sentences regularly _____

Toilet trained during the day
Dry through the night (6+ months) _____

Dressed Self _____

Please indicate if your child is experiencing any of the following:

Problems with eating _____

Isolated from peers _____

- Problems making friends _____
- Problems keeping friends _____
- Problems getting to sleep _____
- Problems Controlling Temper _____

- Problems sleeping through the night _____
- Trouble Waking up _____
- Fatigue/tiredness during the day _____
- Nightmares _____
- Bed wetting _____
- Soiling _____
- Problems with authority _____
- Anxiety _____
- Unmotivated _____
- Stress from conflict between parents _____
- Legal situation (anyone in the family) _____
- History of abuse _____
- Alcohol/drug use/abuse _____
- School concentration difficulties _____
- Grades Dropping or consistently low _____
- Sadness or Depression _____

Please list any special talents, strengths or interests your child has:

Handedness: R L

How does your child respond to music? _____

Vision & Hearing

Does your child wear glasses? (circle) Y N

Comments: _____

Describe your child's ear history (frequent infections, drainage tubes, hearing test results)

Educational Information

Child's School: _____ Grade: _____

Type of School (Circle): Public / Private / Therapeutic / Other: _____

Teacher: _____ Phone: _____

Case Manager: _____ Phone: _____

Other (specify): _____ Phone: _____

Other (specify): _____ Phone: _____

Does your child currently receive any special education services as part of an Individualized Education Plan (IEP) ? Y N

If yes, please describe the educational supports your child receives? (Include classroom setting, related services such as Speech, OT, Social Work, and any other accommodations such as a behavior intervention plan, extended time for tests, note taker etc.)

Would you like information about your child's educational rights? Y N

How would you describe your relationship with your child's educational team?

What feedback have you received from the school regarding your child's participation and performance?

Prior Educational Placements (including preschools)

School: _____ Dates attended: _____

Indicate any specialized services received: _____

School: _____ Dates attended: _____

Indicate any specialized services received: _____

School: _____ Dates attended: _____

Indicate any specialized services received: _____

