Phyllis Yedida Sachs-Yasgur, LCSW-R, EMDR
1029 Teaneck Road, Suite 2B
Teaneck, NJ 07666

845-304-2368

INTAKE QUESTIONAIRRE FOR PARENTS/GUARDIAN

Date_____

PARENT'S NAME_____

NAME OF CHILD (REN)

_____ AGE____ DATE OF BIRTH _____

_____ AGE_____DATE OF BIRTH _____

_____ AGE____ DATE OF BIRTH _____

_____ AGE_____DATE OF BIRTH _____

ADDRESS_____

CITY_____ STATE _____

ZIP_____

How did you hear of our services?

_____

MOTHER' S PHONE: HOME _____CELL/WORK _____

May we leave a message? □ Yes □ No

MOTHER'S E-MAIL:_____
∗Please note: Email correspondence is not considered to be a confidential medium of communication

MOTHER'S EMPLOYMENT STATUS

EMPLOYED __FULL-TIME STUDENT __PART-TIME STUDENT

NAME OF EMPLOYER

_____

‘

MOTHER’S EMERGENCY CONTACT NAME:

_____

EMERGENCY CONTACT PHONE: _____

May we leave a message? □ Yes □ No

EMERGENCY CONTACT E-MAIL:

_____

FATHER’S PHONE: HOME _____CELL/WORK _____

May we leave a message? □ Yes □ No

E-MAIL:_____

∗Please note: Email correspondence is not considered to be a confidential medium of communication

FATHER’S EMPLOYMENT STATUS:

FATHER: EMPLOYED __FULL-TIME STUDENT __PART-TIME STUDENT

NAME OF EMPLOYER

_____

FATHER’S EMERGENCY CONTACT NAME:

_____

EMERGENCY CONTACT PHONE: HOME _____

EMERGENCY CONTACT EMAIL:_____

PARENTS’ MARITAL STATUS

□ **Married** □ **Never Married** □ **Domestic Partnership**

□ **Separated*** □ **Divorced*** □ **Widowed**

***IF PARENTS ARE SEPARATED OR DIVORCED:**

Custody arrangements with the children:

_____

_____

_____

Visitation:

_____

_____

***NOTE**: Please bring a copy of Court Papers re custody and visitation at the time of your first appointment.*

GENERAL HEALTH/MENTAL HEALTH INFORMATION

Have your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/psychiatrist:

_____

Phone _____

Is your child currently taking any prescription medication, including psychiatric medications? □ Yes □ No

If yes, please list and provide dates

_____

_____

Name of your Pediatrician _____

Phone Number _____

How would you rate your child's current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

History of previous hospitalizations:

Date:_____**Problem**_____

Date:_____**Problem**_____

Behavior

- **At School:**
- **At Home:**

Academic Status:

Name of School:

Name of Teacher:

Current Grade:

Academic Progress:

What significant life changes or stressful events has your family experienced recently?

_____

_____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

_____

What would you like to have your child accomplish in therapy?

_____

_____

_____

INSURANCE INFORMATION

INSURED'S NAME
_____

CHILD'S RELATIONSHIP TO INSURED: __SELF __SPOUSE __CHILD __OTHER

PRIMARY POLICY HOLDER'S Name _____

DATE OF BIRTH_____SOCIAL SECURITY#_____

CITY_____STATE_____ZIP_____

PHONE: HOME _____WORK_____

EMPLOYER_____

NAME OF INSURANCE COMPANY_____

INSURANCE ID#_____

(<u>If possible please send or bring picture of the card to the first interview</u>)

GROUP/POLICY#_____

INSURANCE
ADDRESS_____
(from back of Insurance Card)
CITY_____STATE_____ZIP

PHONE_____

SECONDARY INSURANCE (IF APPLICABLE):

INSURED'S NAME_____

DATE OF BIRTH_____SOCIAL SECURITY#_____

CITY_____STATE_____ZIP_____

PHONE: HOME _____WORK_____

EMPLOYER_____

NAME OF INSURANCE COMPANY_____

INSURANCE ID#_____

(<u>If possible please send or bring picture of the card to the first interview</u>)

GROUP/POLICY#_____

INSURANCE
ADDRESS_____
(from back of Insurance Card)
CITY_____**STATE**_____**ZIP**

PHONE_____