**Brock L. McKay, PhD, LLC, Licensed Psychologist**

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**WELCOME: PLEASE COMPLETE THIS INITIAL INTAKE FORM**

Son’s name: Parent’s names:

Today’s Date: Family Physician:

Your son’s date of birth: Age:

Is he adopted? If so, by whom?

Date of adoption: Age at adoption:

Is he aware he is adopted? If yes, age when told?

Is this a blended family? If so, with whom does he live? Please give first and last names and ages:

How often does he see his other parent?

Age when divorce occurred?

Cause of divorce? Was there a separation first?

How old was your son at separation? How long did it last?

Reason for this appointment:

When did this start?

Have there been periods it has been worse?

Have there been periods with it has been better?

What are the primary symptoms that you observe?

What symptoms worry or bother **you** the most?

What symptoms bother **him** the most?

Has there been any change in symptom intensity?

Has there been any change in symptom duration?

What tends to make the problem better?

What tends to make the problem worse?

What do you think might be causing the problems?

Have you ever sought out treatment before? When?

With whom?

How was that helpful?

When was the last time your son saw this person?

Please list below any medication your son is taking currently:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medicine | Dosage | Purpose | Start Date | Physician |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Please list below any medication your son has taken in the past to help the problem:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medicine | Dosage | Purpose | Start Date | Physician |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Please list any surgeries, hospitalizations, illnesses, or medical problems:

Is your son allergic to any medicines?

Please list any allergies to substance or foods:

Any history of falls? If yes, When?

Seizure activity? If yes, Onset? Febrile:

Loss of consciousness? If yes, When? Age:

What happened?

Was he seen by a physician?

Any change in personality or behavior?

Automobile accidents?

Electrical shocks?

Other medical concerns?

Anyone in the family with a serious illness?

Has your son or the family undergone any significant losses?

Any traumas?

Any family history of the following one either mother’s (put M) or father’s (put F) sides of the family? Please include natural grandparents, aunts, uncles, cousins, etc.

Anxiety Panic Attacks Obsessive Compulsive Disorder Perfectionism

Depression Manic Depression/Bipolar Suicide Attempts

Psychiatric Hospitalizations Post Traumatic Stress Attention Deficit Disorder Hyperactivity Drug Use Alcohol Problems Been in Treatment Driving Under the Influence Contact with the Law on Disability

Learning Difficulties Problems Finishing High School Eating Disorders

Cont’d: Any family history of the following one either mother’s (put M) or father’s (put F) sides of the family? Please include natural grandparents, aunts, uncles, cousins, etc.

Sexual Problems Personality Problems Seizures/Epilepsy

Problems with Anger Physical Abuse Sexual Abuse/Molestation

Contact with SRS

Any other family concerns:

DEVELOPMENTAL HISTORY

Was the pregnancy planned: Y N\_\_\_\_ Uneventful: Y N

Difficult: Y N Please describe any complications during the pregnancy:

Describe any problems with delivery:

Did his mother smoke at conception? Y N \_ Smoke during pregnancy? Y N

Did his mother drink alcohol before knowing she was pregnant? Y N Drink during pregnancy? Y N

If Yes, how much per week?

Name any prescription medicines his mother might have taken during pregnancy:

Did his mother take any drugs after conception and prior to knowing she was pregnant? Y N If so, what type?

Any drug use during pregnancy?

DEVELOPMENTAL MILESTONES

Age at walking: At talking: At toilet training:

Nighttime bedwetting: Never Some Often Always Age it stopped

Daytime Wetting: Never Some Often Always Age it stopped

Nighttime Soiling: Never Some Often Always Age it stopped

Daytime Soiling: Never Some Often Always Age it stopped

Describe any repetitive movements:

Any fears:

Cruelty to animals:

Rigidity:

Rituals:

Having to do particular things the same way:

Any developmental delays? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please use the space below to address any important information about your son that was not asked on this form.

I look forward to meeting with you to discuss your son’s needs. ----- Brock L. McKay, PhD, Licensed Psychologist.