

# Dr. Michelle Spader

Licensed Clinical Psychologist • Board Certified Behavior Analyst

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## Intake Form

Person Completing this form \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Child's Gender:  Male  Female  Other: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip County

### Referral History:

1. Who referred your child for psychological assistance?

Physician  School  Employer  Friend  Insurance Company  Internet Search  Other: \_\_\_\_\_

2. Briefly describe the chief problems that are affecting your child and your family: \_\_\_\_\_  
\_\_\_\_\_

3. In what way are you hoping that Dr. Spader can be helpful with these problems? \_\_\_\_\_  
\_\_\_\_\_

4. Does your child have any previous diagnoses (medical or mental health-related): \_\_\_\_\_  
\_\_\_\_\_

5. Please list your child's strengths, what s/he is good at, and/or what s/he likes to do: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's Pediatrician: \_\_\_\_\_ Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

If you would like Dr. Spader to fax a copy of completed records to your child's pediatrician such as the Psychological Assessment Results Report, please check here:  yes  no

### Family Information:

Parent's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Parent's Home #: \_\_\_\_\_ Parent's Home #: \_\_\_\_\_

Parent's Cell #: \_\_\_\_\_ Parent's Cell #: \_\_\_\_\_

Parent's Work #: \_\_\_\_\_ Parent's Work #: \_\_\_\_\_

Email Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Preferred method of contact:

Email  Cell  Home Phone  Work Phone

Preferred method of contact:

Email  Cell  Home Phone  Work Phone

Step-parent's name (if applicable): \_\_\_\_\_ Time known child: \_\_\_\_\_

Step-parent's name (if applicable): \_\_\_\_\_ Time known child: \_\_\_\_\_

Guardian's Name (if different than above): \_\_\_\_\_

Parents are (please circle): Married Separated Divorced Never Married Widowed Deceased

If parents are separated or divorced, who has legal custody? Both/Joint Mother Father Other

If Both/Joint, is the child's other parent aware that you are pursuing these psychological services? yes no

Please describe custody and visitation arrangements, including how often the child sees the parent that s/he does not live with: \_\_\_\_\_

\*Please be aware that both custodians have access to all medical records unless there is a court order stating otherwise.

\*Additionally, if you are bringing your child in for services, and you are divorced/separated from the child's other biological parent, you are responsible for paying any fees associated with my psychological services regardless of which parent the insurance policy is under.

Is this child a foster child? yes no Is this child adopted? yes no

If yes, is this child aware that s/he is a foster or adopted child? yes no

If yes, please give as much information regarding biological parent(s) as you can: \_\_\_\_\_

Who is living in the home at this time? (Please include everyone).

Name	Age	Relationship to Child

Family members living outside of the home. (For example, a biological parent, brothers or sisters).

Name	Age	Relationship to Child

Problem Areas for Family Members:

Has anyone in your family experienced the following (check if yes):

Problem	Check if Yes	Relationship to Child
ADHD		
Anxiety		
Autism Spectrum Disorder		
Behavior Problems		
Bipolar Disorder/Manic Depression		
Depression		
Drug Abuse		
Learning Disability (reading, writing, or math)		
Intellectual Disability/Cognitive Delays		
Language/Speech Disorder		
Suicide Attempt/Completion		
Victim of Physical/Sexual Abuse		
Seizures		
Genetic Syndrome/Disorder		
Other:		

-Please be sure to bring any previous evaluation reports, such as school MFE/ETR and IEP, previous psychological evaluations, and any recent speech or occupational therapy evaluations to your appointment.