Spader Psychological Services, LLC

Michelle Spader-Cloud, PSYD, BCBA-D, COBA

Licensed Clinical Psychologist • Board Certified Behavior Analyst • Central Ohio Behavior Analyst
6260 South Sunbury Road, Suite 5, Westerville, OH 43081 • Phone (614) 852.4152 / Fax (614) 852.4151
contact@spaderpsychology.com • www.spaderpsychology.com

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-Cloud 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-Cloud 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: Preferred method of contact:

□ Email □ Cell □ Home Phone □ Work Phone □ 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 pursing 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.