

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: _____

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, how long has the child been in your home? _____

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).

<u>Name</u>	<u>Age</u>	<u>Relationship to Child</u>

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

<u>Name</u>	<u>Age</u>	<u>Relationship to Child</u>

Problem Areas for Family Members:

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

<u>Problem</u>	<u>Check if Yes</u>	<u>Relationship to Child</u>
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.

Revised September 2017