Melanie Bierenbaum, Psy.D.
Licensed Psychologist
14354 N Frank Lloyd Wright Blvd, Bldg C, Ste 10
Scottsdale, AZ 85260

INITIAL INTAKE EVALUATION

Name of Person Completing Form	
Date	
Relationship to Child	
How did you hear about the practice?	
Best Contact Number	
Emergency Contact Name & Phone Number	

PATIENT INFORMATION

Patient Name	
DOB	
Age	
Ethnicity	
Gender	
Address	
Primary Care Physician (Name, Phone, Address)	

FAMILY INFORMATION

Name	Age	Relation to Patient (Bio Dad, Adoptive Mom, Sister, etc.)	Living in the Home?

PARENT/GUARDIAN MARITAL STATUS

Biological or Adoptive Parent #1 : _____
(name)

□ Married □ Divorced □ Remarried □ Lives with Partner

Biological or Adoptive Parent #2: _____
(name)

□ Married □ Divorced □ Remarried □ Lives with Partner

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PATIENT MENTAL HEALTH HISTORY

	Date(s)	Details
Previously Received Counseling?		
Previous Psychological or Neuropsychological Testing?		
Previous Psychiatric Hospitalization?		
History of self-injurious behavior?		
History of suicide attempt(s)?		

FAMILY MENTAL HEALTH HISTORY

Family Member Name	Relationship to Patient	Diagnosis/Problems

BIRTH HISTORY

In utero exposure to any of the following:

☐ Alcohol ☐Drugs ☐Tobacco ☐ Prescription Medication

Difficulties during pregnancy?

_____

_____

Difficulties during birth?

_____

_____

Problems immediately after birth?

_____

_____

MEDICAL HISTORY

Allergies	
Loss of Consciousness	
Current medical issues	
Major accidents or injuries	
Major surgeries	

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FAMILY MEDICAL HISTORY

Family Member	Relationship to Parent	Medical Diagnosis

CURRENT MEDICATIONS

Medication	Dose	Prescribing Physician

DEVELOPMENTAL INFORMATION

Developmental Milestone	Age Achieved (Estimate)	Ongoing Problems?
Sitting up independently		
Crawling		
Standing		
Walking		
Single Words Spoken		
Sentences Spoken		

PAST OR PRESENT DIFFICULTIES

	Past Problems?	Current Problems?
Toileting		
Eating		
Sleeping		
Vision		
Hearing		
Sensory		

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EDUCATIONAL INFORMATION

Name of School and Current Grade	
Does your child have an IEP or 504 Plan?	
History of Learning Disabilities?	
Grades on Last Report Card?	
History of being Suspended or Expelled from school?	

SOCIAL HISTORY

Gets along with peers?	
Friends outside of school?	
History of bullying?	
Aware of alcohol or drug abuse?	
Extracurricular Activities?	

PRESENTING PROBLEM/CURRENT CONCERNS

Please indicate which of the following prompted you to seek treatment:

☐ Depression ☐ Anxiety ☐ Suicidal Ideation

☐ Self-injurious Behavior ☐ Medication Refusal ☐ Poor Medical Adherence

☐ Overwhelmed with medical diagnosis or Injury ☐ Problems Managing Chronic Pain ☐ Anxiety with Medical Procedures or Treatment

☐ Poor Medical Prognosis ☐ Family Conflict ☐ School Difficulties/Refusal

☐ Behavioral Changes after Brain surgery/Brain Injury ☐ Peer Conflict/Bullying ☐ Feeding Difficulties

☐ Toilet Training Problems ☐ COVID-Related Concerns ☐ Medical Trauma

☐ Medically Unexplained Symptoms ☐ Transitioning to adulthood with a chronic health condition

☐ Other Concerns: _____

History of Problem/Concerns	
When did problems start?	
What makes problems better?	
What makes problems worse?	
Consequences suffered due to problem/concerns?	

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Please identify your child's/teen's strengths:

_____

_____

_____

_____

Any Additional Information that is helpful for me to know:

_____

_____

_____

_____

_____

_____

_____