**ERIN LIEBMAN**
School Psychologist, Reading Specialist, Licensed Clinical Professional Counselor

# Intake Form
## (Adolescent/Adult)

**Please circle the symptoms which are applicable, and indicate the duration which you experienced them:**

| Symptom | Duration | Symptom | Duration |
|---|---|---|---|
| Sadness | | Self-control Problems | |
| Anxiety/Worry | | Attention/Focus Problems | |
| Sleep Changes | | Bullying | |
| Weight Changes | | Suicidal Thoughts | |
| Confusing/Racing Thoughts | | Grief/Loss | |
| Frequent Crying | | Work Problems | |
| Isolation/Loneliness | | Family Problems | |
| Appetite Changes | | Relationship Problems | |
| Restlessness | | Health Problems | |
| Difficulty Concentrating | | Self-Esteem Issues | |
| Moodiness | | School/Learning Problems | |
| Peer Relationship Problems | | (Other) | |

**If Other, please explain:**

**Have you, or your family, ever participated in therapy? Y N**

**If yes, please describe with whom, and for how long? Was it helpful?**

**Please list you past and current medications:**

| Medication | Year | Doctor | Duration |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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**Have you ever been hospitalized for psychiatric reasons? Y N**
**If yes, please describe.**

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**Please describe any medical problems, concerns, or hospitalizations (past and present) that have impacted you.**

**Please list any medical and/or mental health problems that run in your family**

| Medical/Mental Health Problem | Family Member |
|---|---|
| | |
| | |
| | |
| | |

**Please explain your reason(s), for beginning therapy:**

_____ _____
**CLIENT SIGNATURE** **DATE**

_____ _____
**PARENT/GUARDIAN SIGNATURE** **DATE**
**(CLIENT IS UNDER 18)**