

**Mental Fitness Lifestyle, Inc.**  
22231 Mulholland Hwy., Suite 210  
Calabasas, California 91302

OFFICE USE ONLY

Dx Name: \_\_\_\_\_  
Dx Number: \_\_\_\_\_

### CHILD INFORMATION

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Address: \_\_\_\_\_  
  Street  City  Zip Code

Birth Date: \_\_\_\_\_ School: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**Mother:** \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Home Phone #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

PLEASE CIRCLE PHONE NUMBER AT WHICH YOU WOULD LIKE CONFIDENTIAL MESSAGES LEFT

**Father:** \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Home Phone #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

PLEASE CIRCLE PHONE NUMBER AT WHICH YOU WOULD LIKE CONFIDENTIAL MESSAGES LEFT

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Previous Therapy: \_\_\_\_\_  
  Therapist's Name  Period of Time  Therapy Issue

Please describe your child's living arrangements (with whom, time split, etc.) and list any other children in the home(s): \_\_\_\_\_

Name	Age	Relationship	Name	Age	Relationship	Relationship

In case of emergency, please notify: \_\_\_\_\_

Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you to my practice? \_\_\_\_\_

It is customary to thank the referring person. **Your signature below gives me permission to contact and thank this person.** No other information will be disclosed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### INTAKE INFORMATION

Why are you seeking therapy for your child at this time? \_\_\_\_\_

---

---

---

Check any symptoms your child has exhibited in the past six months:

- |  |   |
|--|---|
| <input type="checkbox"/> Sadness/Crying Spells             | <input type="checkbox"/> Nervousness/Jittery            |
| <input type="checkbox"/> Socially Isolated                 | <input type="checkbox"/> Irritable/Temper Outbursts     |
| <input type="checkbox"/> Appetite/Weight Loss              | <input type="checkbox"/> Persistent Thoughts            |
| <input type="checkbox"/> Insomnia                          | <input type="checkbox"/> Mood Swings                    |
| <input type="checkbox"/> Excessive Sleep                   | <input type="checkbox"/> Excessive Worrying             |
| <input type="checkbox"/> Giving Up Easily                  | <input type="checkbox"/> Fidgety                        |
| <input type="checkbox"/> Difficulty Having Fun             | <input type="checkbox"/> Excessive Nightmares           |
| <input type="checkbox"/> Excessive Anger/Hostility         | <input type="checkbox"/> Difficulty Sleeping in Own Bed |
| <input type="checkbox"/> Suicidal Thoughts/Statements      | <input type="checkbox"/> Very Active                    |
| <input type="checkbox"/> Difficulty with Authority Figures | <input type="checkbox"/> Easily Distracted              |
| <input type="checkbox"/> Often in Trouble                  | <input type="checkbox"/> Has Conflicts with Peers       |
| <input type="checkbox"/> Argumentative                     | <input type="checkbox"/> Doesn't Follow Directions      |
| <input type="checkbox"/> Other (please describe): _____    |   |

List and describe any history of emotional disorder(s) in your child's biological family:

---

---

---

List and describe any significant life events (e.g. divorce, death in family, etc.):

---

---

---

How does your child function at school (i.e. grades, with peers with teachers)?

---

---

---

---

List and describe your child's current or historical physical problems (e.g. weight gain, headaches, hypoglycemia, stomachaches, etc.):

---

---

---

---

List any medication(s) and dosage your child is currently prescribed: \_\_\_\_\_

---

---

---

Prescribing Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

What are your child's strengths and hobbies? \_\_\_\_\_

---

---

---

List your three primary treatment goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_