Laura A. Jones, Ph.D. Clinical-Child Psychologist 2525 Blueberry Rd, Suite 107 Anchorage, AK 99503 (907) 277-0607 (907) 277-0061 (fax)

Intake Questionnaire

Child's Name:			Date Completed:		
Birthdate:		Age:		Sex:	
Parent Information:					
Name			Name		
Home Address			Home Address		
City, State, Zip			City, State,	Zip	
Home Phone Number			Home Phone Number		
Work or Cell Phone Number			Work or Cell Phone Number		
What is your main co	oncern about your child?				
Please list all family	momhors				
Name	Relationship to child		Age	Sex	Living in home?

If there are any other people living in your home, please list them.

DEVELOPMENTAL AND MEDICAL INFORMATION

Describe any pregnancy or birth complications:
Describe any developmental delays:
List any health concerns:
List any current medications:
Physician's name(s):
List any previous mental health providers:
SCHOOL INFORMATION Child's School: Grade: Teacher's name:
CURRENT CONCERNS

Please circle any of these problems that apply to you or your child:

anxiety	attention deficit disorder	parenting difficulties
depression	school problems	divorce/custody
anger	learning difficulties	alcohol/drugs
fears	developmental delays	relationship difficulties
noncompliance	physical complaints	legal difficulties
sleep problems	suicidal statements	sexual behavior
autism spectrum disorder	suicidal behavior	child abuse/neglect
Other concerns:		

Please read the Psychotherapy Services Agreement prior to signing this form. You may ask me to clarify any issues or policies that are unclear to you. The initial consultation cannot begin until you have signed this form.

"I have read this questionnaire and I understand and agree to all of the conditions with respect to confidentiality and fees. My signature indicates my willingness to abide by these conditions."

Signature