Elanna Lazaruk, PsyD
3 Hillside Place
Ardsley, NY 10502
Phone: (914) 500-8448
Fax: (914) 478-1048

Child/Adolescent Intake Form

Contact information

Child Name:_____

Address:_____
(Street) (City) (State) (Zip code)

Home number:_____ Can I leave voicemail: ☐ Yes ☐ No

Mobile number:_____ Can I leave voicemail: ☐ Yes ☐No

Email address:_____

Preferred method of communication:_____ Referred by:_____

Personal Information

Dob:_____ Age:_____ Gender:_____

School: _____Grade: _____

Siblings:_____

Guardian Information

Name:_____ Do you have legal custody: ☐Yes ☐No

Relationship Status: ☐ married ☐ single ☐ domestic partnership ☐ separated ☐ divorced
☐ widowed ☐ Other: _____

Presenting Problem

Reason for coming: _____

_____

Emergency Contact Information

Name: _____ Relationship to you: _____

Address: _____
(Street) (City) (State) (Zip code)

Phone: _____ Email: _____

Medical History

Pediatrician:_____ Phone Number:_____

Have you had prior psychotherapy? ☐ Yes ☐ No

- If yes, with who:_____ For how long:_____
- For what concerns: _____

Have you ever been prescribed any psychiatric medications? ☐Yes ☐No

- If yes what medications:_____

List any medical problems: _____

Please list current medications: _____

Allergies: _____

Family Health History

Family history of mental health: _____

Family history of medical concerns: _____