Robin Sakakini, Psy.D.
Licensed Psychologist
PSY 25438

ADOLESCENT INFORMATION

Name:_____ Date:_____

Home Address:_____
Street City Zip Code

Home Phone #:_____ Cell Phone #:_____

Email: _____

Is it ok to leave a message on your (Circle all that are ok):

Home # Cell # Email

Birth Date:_____ School:_____

Grade:_____ Teacher:_____

Name of Mother:_____ Occupation:_____

Name of Father:_____ Occupation:_____

Previous Therapy:_____
Therapist's Name Period of Time Therapy Issue

Physician:_____ Phone #:_____

Please describe your living arrangements:

_____ _____
Name Age Relationship Name Age Relationship

_____ _____
Name Age Relationship Name Age Relationship

In case of emergency notify:_____ 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:_____

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INTAKE INFORMATION

Why are you seeking therapy at this time? _____

_____

_____

Check any symptoms you have exhibited in the past six months:

___ Sadness/Crying Spells
___ Socially Isolated
___ Appetite/Weight Loss
___ Mood Swings
___ Giving Up Easily
___ Difficulty Having Fun
___ Excessive Anger/Hostility
___ Suicidal Thoughts/Statements
___ Sexual Dysfunction
___ Lethargy
___ Long Periods of Elation
___ Nervousness/Jittery
___ Irritable/Temper Outbursts
___ Persistent Thoughts
___ Excessive Worrying
___ Fidgety
___ Peer/Family Conflicts
___ Self Mutilation
___ Overeating/binging
___ Panic Attacks
___ Intrusive Thoughts
___ Excessive Fears
___ Other (please describe): _____

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

_____

_____

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

_____

_____

_____

How do you function at school (i.e. grades, with peers, with teachers)?

_____

_____

_____

List and describe any drug and/or alcohol use: _____

_____

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

_____

List any medication(s) and dosage you are currently prescribed: _____

_____

What are your strengths and hobbies? _____

_____