Bebe Brezanin-Brusky, MSW, LCSW

Licensed Clinical Social Worker
Adolescent, Adult & Couples Counseling
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908-208-2119

Intake and Assessment – Part 1/Minor

Client Name: _____
Referral Date: _____
Referral Source: _____

Demographics
Today's Date(s)_____
Client Name: _____D/O/B_____ Age:_____
Ethnicity:_____
Address: _____
Phone (H)_____ (W)_____(C) _____
Preferred telephone number to call you at _____Ok to leave a message?_____
Emergency Contact (name, phone #, relationship)_____
_____
Email: _____

(If child)Is child adopted/or foster? Yes no If yes, age when adopted/foster and circumstances _____
_____

Parent/guardian information

Parent/guardian #1 or spouse (if applicable)

Last name _____first name _____

Address: _____

Phone: (H)_____ (W) _____ (C) _____

SS #_____D/O/B_____ Age_____

Marital status: single married separated divorced widow/widower domestic partnership (circle)

Employer's name and address _____
_____

Parent/guardian #2 or spouse (if applicable)

Last name _____first name _____

Address: _____

Phone: (H)_____ (W) _____ (C) _____

SS #_____D/O/B_____ Age_____

Marital status: single married separated divorced widow/widower domestic partnership (circle)

Client Name: _____

Employer's name and address _____

_____

Employer's name and address _____

_____

Others in the home

Please list all other adults/children in the family/home

Name relationship age grade in school/employment in home?

_____

_____

_____

_____

_____

School name, address & phone _____

_____

Medical Information -Current/Past Professional Providers

Reason for coming to therapy now _____

_____

Family Physician _____
Address _____
Phone _____ Date of last visit _____
Reports requested _____ Date of signed Authorization _____
Date Authorization sent _____

Psychiatrist _____
Address _____
Phone _____ Date of last visit _____
Reports requested _____ Date of signed Authorization _____
Date Authorization sent _____

Therapist _____
Address _____
Phone _____ Date of last visit _____
Reports requested _____ Date of signed Authorization _____
Date Authorization sent _____

Neurologist _____
Address _____
Phone _____ Date of last visit _____
Reports requested _____ Date of signed Authorization _____
Date Authorization sent _____

Previous Psychiatric or Chemical Dependency Treatment (including provider, type/level of care, DOS and treatment outcomes)

Medication

List all current and past psychotropic and other medications (including over the counter)

Medication	Current/ past	Date started	Prescribing MD	Dosage	Response	Purpose

Revised 2/8/2014