

**PEMBERTON COUNSELING SERVICES, PSC**  
**STUDENT COVER**  
**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ Sex:  Male  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_

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

School: \_\_\_\_\_ School Phone: (\_\_\_\_\_) \_\_\_\_\_

Employer : \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Does anyone else have access to your email address?  Yes  No

Do you give permission for us to use email to correspond?  Yes  No Signature: \_\_\_\_\_

**RESPONSIBLE PARTY and/or GUARDIAN'S INFORMATION**

Responsible Party: \_\_\_\_\_

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

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Responsible Party's Marital Status:  Single  Married  Separated  Divorced  Widowed

Responsible Party's Spouse's Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**CONFIDENTIALITY:** Interactions between client and counselor are confidential. Unless the therapists of Pemberton Counseling Services, PSC have permission, we will not discuss anything that transpires between us with anyone. There are four major exceptions to confidentiality that Kentucky Law requires all mental health professionals to report:

1. Incidences of child or elder abuse or neglect
2. Intent to commit suicide.
3. Threats to do harm to yourself or another person.
4. Court order.

Additionally, in the event of a billing dispute, names, dates and lengths will be disclosed.

**APPOINTMENT CANCELATION POLICY:** Pemberton Counseling Services, PSC require that cancellations for scheduled appointments be received 24 hours in advance during regular office hours (Monday through Friday 8:00am to 5:00pm). **Unkept or cancelled appointments that do not follow this policy will be charged an unkept appointment fee at the discretion of your therapist or doctor.** This fee can equal but will not exceed the therapist/doctors fee for the time originally scheduled. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge.

***I have read and understand the above stated policies of Pemberton Counseling Services PSC.***

***Signature of Responsible Party (required):*** \_\_\_\_\_

***Signature of Patient*** \_\_\_\_\_

# PEMBERTON COUNSELING SERVICES, PSC

1700 UPS Dr., Suite 107  
Louisville, KY 40223

Phone: (502) 327-8045  
Fax: (502) 327-7227

www.pembertoncounseling.com

## Student Intake Questionnaires

In order for us to be able to fully evaluate you, we request that you fill out the following intake form and questionnaires to the best of your ability. Any questions that require additional space to answer, please note on question and finish answer on the back. We realize that there is a lot of information and you may not remember or have access to all of it; do the best you can. Thank you!

### STUDENT'S IDENTIFICATION

Name \_\_\_\_\_ First Appointment Date \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_  
 Natural Mother \_\_\_\_\_ Natural Father \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_  
 Parent Work # \_\_\_\_\_ (specify) mom or dad  
 Who are you currently living with? \_\_\_\_\_

### REFERRAL SOURCE

Referral Source \_\_\_\_\_  
 Referral Address \_\_\_\_\_ Phone # \_\_\_\_\_  
 Do we have your permission to release information to the referring professional when it is appropriate?  
 Yes \_\_\_ No \_\_\_

### MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**WHY DID YOU SEEK THE EVALUATION AT THIS TIME?**

Why did you come into the office for help?

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**PRIOR ATTEMPTS TO CORRECT PROBLEMS**

Have you had previous counseling or psychiatric help? Please check all that apply.

**Individual Counseling:**  
If yes, when and where did you receive counseling and what were the issues? Did you feel that this helped?

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**Group Counseling:**  
If yes, when and where did you receive counseling and what were the issues? Did you feel that this helped?

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**Hospitalization:**  
If yes, when and where did you receive counseling and what were the issues? Did you feel that this helped?

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**MEDICAL HISTORY**

MEDICATION	DOSAGE	START DATE	END DATE

Any history of head trauma? (describe): \_\_\_\_\_

Any seizures or seizure like activity? \_\_\_\_\_

Any periods of spaciness or confusion? \_\_\_\_\_

Prior hospitalizations (place, cause, date, outcome): \_\_\_\_\_

Prior abnormal lab tests, X-rays, EEG, etc.: \_\_\_\_\_

Allergies/drug intolerances (Please list): \_\_\_\_\_

\_\_\_\_\_

*Present Height* \_\_\_\_\_ *Present Weight* \_\_\_\_\_ *Change in last 3 months* \_\_\_\_\_ *# meals per day* \_\_\_\_\_

**Current Stresses** (please list current factors that are a source of stress in the family, at school, or among friends)

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**FAMILY HISTORY**

**Family Structure** (who lives in the current household with you)

NAME	AGE	RELATIONSHIP TO YOU

**What is your parents' current Marital Situation/Satisfaction?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Family Development** (include marriages, separations, divorces, deaths, traumatic events, losses, etc. of family)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Natural Mother's History:** age \_\_\_\_\_ outside work \_\_\_\_\_

School: highest grade completed \_\_\_\_\_

**Natural Father's History:** age \_\_\_\_\_ outside work \_\_\_\_\_

School: highest grade completed \_\_\_\_\_

**(If Applicable)**

**Step or Adopted Mother's History (indicate which):** age \_\_\_\_\_ outside work \_\_\_\_\_

School: highest grade completed \_\_\_\_\_

**Step or Adopted Father's History (indicate which):** age \_\_\_\_\_ outside work \_\_\_\_\_

School: highest grade completed \_\_\_\_\_

**Siblings** (names, ages, relationship to patient)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Who was your primary caretaker, first year** \_\_\_\_\_

\_\_\_\_\_ thereafter \_\_\_\_\_

**Sleep behavior:** sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

\_\_\_\_\_  
\_\_\_\_\_

**Separations from mother and/or father:** age, duration, reaction to \_\_\_\_\_  
\_\_\_\_\_

**Sexual development:** gender identity \_\_\_\_\_  
any problems \_\_\_\_\_

**Physical/Sexual Abuse** (any history of this occurring?): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Drug/Alcohol History:** \_\_\_\_\_  
Do you smoke cigarettes?  YES  NO How many per day? \_\_\_\_\_  
Do you consume alcohol?  YES  NO How many drinks per: Day \_\_\_\_\_ Week \_\_\_\_\_  
Do you take any non-prescribed (recreational) drugs?  YES  NO  
If yes, what and how often? \_\_\_\_\_  
\_\_\_\_\_

**School History:** current grade \_\_\_\_\_ school contact \_\_\_\_\_  
number of schools attended \_\_\_\_\_ average grades \_\_\_\_\_  
homework problems \_\_\_\_\_  
specific learning disabilities \_\_\_\_\_  
strengths \_\_\_\_\_  
what have teachers said about the child/teen \_\_\_\_\_  
\_\_\_\_\_

**Overall Strengths -- as viewed by parents** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Overall Strengths -- as viewed by the adolescent**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please bring school report cards and any state, national or special testing that has been performed*

\_\_\_\_\_

