THERAPY Connections Phone: 763-270-0054 FAX: 763-208-6371

DBT Intake Form

Referral Source: _____ Phone: _____ Date: _____

Client Name:_____DOB:_____Age:_____

Address:_____

Parent Name(s):_____Phone:_____

Address: ☐ Same as parent ☐ Custody issues:_____

_____

Additional professionals providing services: _____

_____

Social Service/Legal issues:_____

Previous/Existing Medical Conditions: _____

Medications: _____

Diagnosis: _____

School Hx: Elementary/Middle/High School:_____

Presenting Problems:_____

_____

Target behaviors: _____

Brief Family Hx: _____

_____

Concerns:

☐ Anger problems ☐ Chaotic relationships ☐ Abandonment fears ☐ Self-harm

☐ Sense of emptiness ☐ Impulsive behavior ☐ Paranoia

Primary Insurance: _____**ID#** _____**Group#**_____

Policy Holder: _____DOB: _____Relationship:_____

BCBS #: _____ P.H. Address: _____

Secondary Insurance:

_____**ID#**_____**Group#**_____

Policy Holder:_____ DOB:_____

Assessment Date: _____ Time: _____ Date Paperwork Mailed Out: _____

Group Night: Monday Tuesday Thursday